Northumbria Police Custody Health Needs Assessment 2012

Professor Charlie Brooker
Honorary Professor of Mental Health and Criminal Justice
University of Lincoln

Ms Coral Sirdifield
Research Assistant
University of Lincoln

Professor Karen Tocque
Honorary Professor of Health intelligence
Glyndwr University

Mr Martin Brown
Independent Consultant

Inspector Andrew Leighton
Ex-Inspector
Lincolnshire Police

Dr Julie Parkes
Senior Lecturer in Public Health
University of Southampton

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1.Literature Review

1. Police custody and health

Individuals detained in police custody may be in need of a medical examination or a health intervention for a variety of reasons including: assessing injuries sustained prior to detention, providing medication; assessing their need to be transferred to a hospital for treatment; assessment of drug/alcohol use; collection of samples (for example in sexual assault cases); assessment of competence, or assessment of whether they should be accompanied by a vulnerable adult (BMA, 2009). Indeed, arguably police custody provides a key point of contact with health services for individuals who may otherwise be hard-to-reach, and whose contact with health services may be inversely proportionate to their level of need (DH, 2007; Bradley, 2009). However, in his review of people with mental health problems or learning disabilities in the criminal justice system, Lord Bradley described police settings as "the least developed in the offender pathway in terms of engagement with health and social care services" (2009: 34).

The basic legal framework within which Custody services operate is provided by the Police and Criminal Evidence Act 1984 (PACE) and the associated Codes of Practice, specifically Code C. Further guidance has been provided by the Association of Chief Police Officers (ACPO), notably the *Guidance on the Safer Detention and Handling of Persons in Police Custody* (2006), which although not a legal requirement is the yardstick against which police are judged by investigating authorities or during litigation in the event of an adverse incident in Custody. More recently further guidance in relation to mental health issues has been provided in *Guidance On Responding To People With Mental Ill Health Or Learning Disabilities* (2010).

Traditionally Custody Sergeants have completed a risk assessment with detainees to decide whether they are in need of healthcare or of an Appropriate Adult, and when needed, healthcare services have been provided by registered medical practitioners (often called 'Forensic Medical Examiners'). To date, very little research has been conducted into the health needs of detainees in police custody. However, Northumbria Police Force is one of ten pilot sites in which provision of healthcare services in custody will be transferred to the NHS – the so-called 'early-adopter' scheme. Consequently, the North East Offender Health Commissioning Unit have commissioned a health needs assessment to ensure that there is a full understanding of both the health needs of detainees in Northumbria, and any gaps in current service provision, in order to ensure appropriate service provision in the future. The small volume of existing literature in this area points to detainees experiencing a wide range of health conditions, many of which need active support whilst in custody.

For example, in their questionnaire survey of 168 detainees seeing a Forensic Medical Examiner (FME) in police custody in London, Payne-James et al (2010) found that 56% of their sample had 'active medical conditions' in need of management whilst in detention. They state that "mental health issues and depression predominated making up 32% of such issues, but there was a very large range of complex, mixed disease and pathology" (2010: 16). Of the 70 (78%) of these individuals who were on prescribed medication, 35 were not taking it regularly. Overall, detainees reported dependence on a range of substances, with 33.9% being heroin-dependent, 33.9% being dependent on crack-cocaine, 25% on alcohol, 16.6% on benzodiazepines and 63.1% on cigarettes.

Similarly, using anonymised police records for detainees seeing a FME in the London Metropolitan area, McKinnon and Grubin (2010) highlight a wide range of physical and mental health problems experienced by this group. In addition, this study pointed to statistically significant differences between the recording of drug, alcohol and mental health problems by Custody Sergeants and the recording of the same problems by FMEs – suggesting that relying on risk assessments completed by Custody Sergeants alone may produce an under-estimation of the extent of health problems experienced by detainees.

This issue is also identified in the Bradley Review, and in a health needs assessment of detainees in police custody in West Yorkshire. In the West Yorkshire project, police custody records from April 2008 to March 2009 were analysed to investigate the range of physical and mental health problems reported. The most frequently recorded physical health complaint was asthma, affecting 14% of detainees. The most frequently recorded mental health problems were depression (70.7%) and history of self-harm (47.8%). Overall, 38.2% of detainees had a dual diagnosis, that is, had both a mental health and a substance misuse problem. However, the author notes that the risk assessments are based on self-report in an environment which may be conducive to under-reporting of health problems which carry a stigma. Furthermore, detainees are often admitted under the influence of drugs and/or alcohol, making identifying other health problems problematic. This is likely to be further compounded by a lack of mental health awareness training (Bradley, 2009).

There have also been several studies of new models of healthcare provision in police custody settings (see for example Bond et al., 2007; Viggiani et al., 2010; Elvins et al., 2012). Elvins et al., (2012) studied the introduction of nurse-led healthcare in police custody settings in Tayside. This study provides some insight into the range of healthcare problems likely to be experienced by detainees as it found that nurses undertook a wide range of activities with detainees including administration of medication, offering brief alcohol interventions, injury assessments, substance withdrawal management, and mental health assessments. These studies also point to the potential for services which include custody nurses to reduce response times and for nurses to take on some of the functions which have traditionally been provided by FMEs, allowing FMEs to focus on the more complex forensic cases (Bond et al., 2007) – an area which is further explored later in this report.

2. Investigation into Current Service Provision

Forces are subject to a rolling programme of thematic inspections by Her Majesty's Inspectors of Constabulary to ensure compliance with legislation and best practice, and Northumbria was subject to such an inspection of its custody facilities and practices in August 2011. The observations and recommendations of this inspection are available online (HMIP and HMIC, 2011).The following section summarises existing health service provision across the Northumbria Police Force area, drawing on the findings of the above thematic inspection.

Northumbria Police currently provide medical services into their Custody suites by use of contracted Forensic Medical Examiners (FME); they also have access to a range of drug and alcohol intervention services (some intensive) and mental health support. There are currently over 20 FME's contracted to Northumbria Police, effectively split into two teams to provide cover of at least one FME North and South of the Tyne at any time. The FME's, generally GPs, mix their police responsibilities with maintaining their own practice and surgeries, which has the potential to limit availability. A survey conducted as part of an unannounced HMIC inspection of custody suites run by Northumbria Police in 2011 stated that whilst there were service level agreements with the FMEs, and the police checked their registration with the General Medical Council every six months, there was no regular monitoring of performance indicators. However, this was expected to be developed later in 2011/12 (HMIC, 2011: 25). A survey conducted as part of this inspection indicated that "only 35% of detainees seen by a FME rated the quality of care as good or very good" (HMIC, 2011: 25).

> *"New detainees were asked if they wanted to see a doctor and custody officers also referred them if they presented any health-related concerns. Call out and response times were entered on the custody record. The target was 60 minutes or 90 minutes if a journey of longer than 30 miles was involved. In our sample, the average response time was 51 minutes, the longest being two hours 46 minutes. Custody staff were generally satisfied with the responsiveness of doctors" (HMIC, 2011: 27)*

There are five designated NHS Section 136 suites within the Northumbria Police area which limit the requirement to bring persons detained under the Mental Health Act into police Custody suites; there are also two Sexual assault Referral Centres (SARC), locally referred to as REACH Sunderland and REACH Newcastle. Mental health services are provided by Northumbria, Tyne and Wear Mental Health NHS Trust and the HMIC report described the relationship between the police and the Trust as good.

A report by Dyer et al., (2009) states that previously Veritas Management Ltd provided custody nurses for a six-month pilot. However, this company ceased to operate and the contract was not renewed. Furthermore, although Criminal Justice and Liaison services, (police and court diversion), across the area are provided by Northumberland, Tyne and Wear Mental Health NHS Trust, coverage is inconsistent. Sunderland and Northumberland do not have any access to this kind of service. A service does operate in Gateshead, but this lacks a formal operational policy, and whilst a service exists in Newcastle, this is only available to Magistrates courts, not to the police (Dyer et al., 2009).

An intensive drugs intervention service is available in some police stations in which every individual arrested for an offence type which has been shown to be linked to substance misuse (e.g. theft) is screened for drug use. Those who screen positive are then required to complete a two-part assessment with a drugs worker (Dyer et al., 2009). Drugs services are provided by the North East Council on Addictions for the north of the force and by Turning Point Criminal Justice Intervention Team elsewhere.

The HMIC report states that “Substance use services were well developed, but there were gaps in provision for alcohol misuse. Mental health diversion services varied, with some significant gaps, but Section 136 mental health provision was adequate” (HMIC, 2011: 5). The report also noted several ways in which healthcare provision could be improved including:

- Making leaflets detailing local support services available to detainees on release
- Ensuring that detainees are routinely told how to make a complaint “in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody” (p24)
- Improving access to female health professionals

The report speaks positively of the level of training that custody staff in this area have received, stating that:

> *“All custody staff received mental health awareness training during induction and all said this had been updated in the lat two years. The NPIA ‘NCALT’ mental health awareness e.learning materials were available to staff online. Custody staff at Gateshead had received a more intensive update in the last eight months provided by the CPN and a custody sergeant with a special interest. As part of the Bradley response plan, a force-wide review of mental health awareness training was under way” (HMIC, 2011: 29).*

The HMIC report states that when their inspection was conducted “there were several joint operational policies and protocols for mental health working, including an information-sharing protocol, a multi-agency risk assessment conference (MARAC) protocol and a section 136 protocol. The police and partner agencies were involved in planned responses to the Bradley report recommendations” (HMIC, 2011: 28).

However, the provision of mental health in-reach services was inadequate. “NHS legacy funding shortfalls for mental health diversion services were hampering progress. At Gateshead, a full-time community psychiatric

nurse (CPN) worked between police custody and the courts to ensure that those with mental health problems received appropriate assessment and referral to mental health services. At Bedlington, the NTW Northumberland Criminal Justice Mental Health Liaison Team provided two community mental health workers to work in police custody and courts from 7am to noon on weekdays to identify detainees with mental health problems. The Bedlington scheme was unfunded. The workers, MHCO staff (the Northumberland IAPT provider), substance misuse staff and a youth offending team worker were generating data to support a business case for permanent funding to present to the primary care trust. There was also half the time of a CPN detailed to provide support to people detained at the courts in Newcastle. Other than these services, mental health workers did not routinely visit police custody suites. However, custody officers said that local crisis resolution teams were usually responsive to telephone referrals. NTW had applied to the Regional Offender Diversion Project for funding to introduce more equitable services across Northumbria and the outcome was awaited" (HMIC: 2011: 28-29).

HMIC Audit of Equipment and Infection Control

Medical provision into Custody was included in the recent HMIC report, and to avoid extensive and unnecessary paraphrasing, the relevant parts for the audit of equipment and infection control are reproduced below.

6.4 There were clinical rooms in the full-time and part-time custody suites but not at the football grounds of Saint James' Park or the Stadium of Light. All rooms were dedicated to health care, apart from South Shields, where the door was open as custody staff required access to the toilet, and Washington, where the custody suite photocopier was in the clinical room and accessible to all staff. The size and shape of clinical rooms varied from large at Etal Lane and South Shields to very small at Hexham. Some part-time suites such as Alnwick and Hexham appeared to be in a state of decommission. Apart from at North Tyneside, every room was untidy and cluttered.

6.5 We were told that there was good attention to the privacy and confidentiality of detainees during consultations with clinical room doors closed, although privacy screens were not available in every room. Paper rolls were used to cover the examination couches. There was no evidence that an infection control audit had been carried out and none of the clinical rooms met expected standards. Also apart from at North Tyneside, examination couches, fixtures and fittings were worn, torn, tarnished or badly chipped. Examination lights were not available in all clinical rooms. Hand washing materials were not available near some sinks and cotton sheet towels were used at Hexham. Rooms were grubby and several had ingrained dirt. Officers said there was daily cleaning but there was no written record of this. Several clinical rooms required deep cleaning.

6.6 All clinical rooms, apart from at North Tyneside, contained medical equipment and supplies that were out of date, including dressings, syringes and needles. Overall clinical stock control appeared haphazard and most cupboards were disorganised. Across the rooms, sharps bins were not secured to the wall or signed and dated when first used. Apart from rooms used by substance use workers, we did not see patient information leaflets in the clinical rooms other than at Bedlington. No health screening or promotion materials were on display. Written clinical guidelines were substantially out of date including at Hexham where we found the Sexual Offenders Training Manual from 1992 and at Southwick a St John Ambulance First Aid Manual from 1987.

6.7 The medicines management system was safe and effective. Stock was kept in locked cabinets and tightly controlled against a reasonable stock list.

Stock cupboards were tidy and contained only full containers of medicines that were sealed by the police until used. There were daily written checks of divertible medicines, specifically diazepam and dihydracodeine tablets. This stock was audited weekly by a non-custody senior police officer. Stock counts were accurate.

FMEs could supply and administer a range of medicines and prescribe medications to be given subsequently by custody staff.

Custody staff administered medications only when prescribed and dispensed by a doctor. Medicines were administered from stock from the locked cabinet and checked by two officers. Pharmacological reference materials were out of date at Bedlington (2007) and Gateshead (2005) among others. Of detainees previously on medications, 39% in our survey said they had been able to continue it in custody.

Custody staff tried to retrieve medications from detainees' homes if necessary and made efforts to assist detainees on programmes of methadone maintenance, usually by escorting them to a local chemist for supervised self-administration. Symptomatic relief was prescribed for those withdrawing from substances and alcohol.

6.8 Emergency equipment was available and included first aid kits, limited resuscitation equipment and automated external defibrillators, which were easily accessible. The kits were regularly checked but dusty. Oxygen was not available for use yet there were ambu-bags and oxygen tubing at Etal Lane and Gateshead. Suction units were not available at all sites. Custody staff we spoke to were up to date with their resuscitation training. Eye wash fluid was out of date in the clinical rooms and other places in the custody suites, including North Tyneside. We saw opened bottles of sterile water in clinical rooms and in the cupboards at several suites, including Clifford Street and Southwick, which suggested that opened sterile fluids were being reused.

HMIC Recommendations

6.9 Clinical governance arrangements should be improved, including clear lines of accountability for checking the training, clinical supervision and appraisal of all forensic medical examiners.

6.10 There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first aid and resuscitation equipment that is checked regularly.

HMIC Housekeeping points

6.11 Detainees should be able to see a female health professional on request

6.12 Out of date clinical reference materials should be discarded and replaced by up to date materials

6.13 All used and out of date clinical stock should be disposed of and regular checks of expiry dates instigated

6.14 Patient information leaflets should be accessible in the clinical rooms

6.15 Out of date pharmacological reference materials should be discarded and replaced by up to date materials

3. Creating Multidisciplinary Healthcare Teams in Custody Environments

Since the first of April 2003, revisions to the Code of Practice C under the Police and Criminal Evidence Act 1984 have permitted Chief Officers to broaden the range of healthcare professionals involved in the treatment of detainees in police custody. Consequently, care can now be provided by FMEs, nurses, psychiatric nurses and paramedics. Guidance on the creation of multi-disciplinary teams is provided in the National Protocol on Custody Care, and Home Office Circular 020/2003. The latter states that if such teams are created it is important to produce local protocols to ensure that:

- Healthcare staff do not work outside of their normal scope of competence without having received appropriate training (e.g. in relation to Section 136 detentions)
- Roles of healthcare staff and chains of responsibility are clearly defined
- The relationship between police and custody healthcare staff, and external healthcare resources is clearly defined
- Arrangements for clinical supervision and clinical governance are clear to all staff within the custody environment

In addition, it recommends that healthcare staff receive training on the procedures covered by the revised PACE Code C and on custody suite procedures. It also recommends that, where appropriate, healthcare staff could undertake further training in areas such as self-harm, substance misuse or assessing the child victims of alleged sexual assault/abuse. Annex A of the circular provides a guide relating to the competencies of police surgeons (FMEs), nurses and paramedics to working in a custody environment this has been summarised In Appendix A.

2. Commissioner Specification

The overall objectives of this health needs assessment are as follows:

1. To complete a health needs assessment and gap analyses to provide an evidence base that enables the commissioning of health services appropriate to the needs of offenders in police custody in Northumbria
2. To capture, collate and interpret data about the services currently being provided to detainees in Northumbria
3. To identify and report patients' needs and preferences for their care
4. To capture, collate and interpret data about secondary care/emergency services and telemedicine resource use and make suggestions for efficient access to appropriate services
5. To identify and describe the opportunities for enhancing self-care and patient/carer empowerment
6. To complete an audit of equipment and infection control across the area

A summary of the tender can be found in Appendix B. It should be noted that, in addition, to the work outlined in Appendix B it was further agreed that a series of case studies would be included (see Module Two). The case studies examined the relationship between prolific offending and health service use in custody as it did not prove possible to identify individuals in Module 2.

3. Findings

Module One

3.1 An Overview of Northumbria Police Force

The Area

Northumbria Police serves a population of 1.5 million people and covers an area of more than 2,000 square miles in the North East of England, from the Scottish border down to County Durham, and from the Pennines across to the North East coast (Northumbria Police, 2012). The police area covers the rural Non Metropolitan County of Northumberland and the industrial and post industrial Metropolitan County of Tyne and Wear, and within those boundaries the population is overwhelmingly concentrated in the South East of the Force area within Tyne and Wear. Northumberland is the most sparsely populated County in England with a population density of only 62 persons per square kilometre. This contrasts sharply with the comparable figure for Tyne and Wear of 2049 persons per square kilometre and an all England average of 398 (ONS, 2012).

Even within Northumberland there are significant differences in population distribution with roughly 50% of the population concentrated in 5% of the area - specifically in the south east urban areas of Ashington, Blyth, Cramlington and Bedlington. These communities are located in the extreme south east of the County of Northumberland adjacent to the Tyne and Wear conurbation and can usefully be thought of as a continuation of that population centre. The population within the police area is relatively homogeneous in terms of race and diversity with only 2.36 per cent of the population in the Northumbria Police area being from Black, Asian or other minority ethnic communities as against 7 per cent nationally (Northumbria Police, 2012).
To assist in understanding the makeup of the area covered by Northumbria Police comparison figures are shown at Table 1 below. Northumbria Police Force covers the metropolitan districts of Newcastle upon Tyne, Gateshead, South Tyneside, North Tyneside and Sunderland as well as the more sparsely populated rural unitary authority of Northumberland. Life expectancy and levels of benefit claims and crime are worse in the more densely populated and more deprived urban areas compared with the less deprived rural district (Table 1).

Table 1: Northumbria Police Area - Community Comparison.

	Population [1,000s]	Area [Km^2]	Density People/Km^2	CRIME [a]	Benefit Claimants % [b]	HEALTH [c]
TYNE AND WEAR	**1,106**	**540**	**2,049**	**39.4**	**Not published**	**76.4 / 81.7**
Gateshead	191	142	1,340	35.1	21.3	76.4 / 80.6
Newcastle on Tyne	284	113	2,506	51.3	17.9	76.2 / 81.6
North Tyneside	197	82	2,393	24.3	18.1	76.8 / 81.0
South Tyneside	152	64	2,367	36.8	23.3	76.6 / 80.8
Sunderland	282	137	2,049	42.1	22.5	75.9 / 80.7
Northumberland	**311**	**5,013**	**62**	**24.5**	**16.3**	**78.5 / 81.7**
Alnwick	33	1,080	30	17.5	Not published	Not published
Berwick on Tweed	26	972	27	25.3	Not published	Not published
Blythe Valley	81	70	1,151	26.5	Not published	Not published
Castle Morpeth	50	618	81	25.4	Not published	Not published
Tynedale	59	2,206	27	15.7	Not published	Not published
Wansbeck	62	67	928	32.9	Not published	Not published
ENGLAND	**51,810**	**130,279**	**398**	**44.7**	**16.3**	**78.3 / 82.3**

Notes:

Sources: Office of National Statistics; Regional Trends Online Tables, June 2011 Release

[a] Recorded Crime BCS comparator figures/1000 population.

[b] Proportion of men aged 16-64 and women aged 16-59 claiming one or more key benefits.

Key benefits include Jobseeker's Allowance (JSA), Income Support(IS), Incapacity Benefit(IB), Severe Disablement Allowance(SDA), Disability Living Allowance(DLA), Carer's Allowance(CA) and Bereavement Benefit(BB)/Widow's Benefit(WB) for working age claimants (including Pension Credit for males aged 60 to 64).

[c] Life expectancy at birth Male/Female

Although the figures quoted, unless otherwise stated, are from a 2011 publication from the Office of National Statistics the underlying datasets are of varying age and should be relied upon as an indicator only (ONS, 2011).

Force Organisation

The Force has an annual budget for 2011-12 of £287.7m (Northumbria Police, 2011) and comprises 3,917 Police Officers, 1,611 Police Staff, 297 Special Constables and 422 Community Support Officers (CSOs) (Northumbria Police, 2012). In common with all police Forces funding and staffing arrangements are under review in the light of the Comprehensive Spending Review. In the financial year 2010/2011 the Force dealt with 68,626 recorded crimes and processed 71,980 detainees [DP] in the calendar year to June 2011 (Northumbria Police, 2012; HMIP and HMIC, 2011).

In common with normal policing practice the Force is organised into Basic Command Units [BCU] which mirror local authority boundaries as follows:

- **North Tyneside** – North Tyneside Council [www.northtyneside.gov.uk/]
- **Newcastle** – Newcastle City Council [www.newcastle.gov.uk/]
- **Gateshead** – Gateshead Council [http://www.gateshead.gov.uk/]
- **South Tyneside** – South Tyneside Council [www.southtyneside.info/]
- **Sunderland** – Sunderland City Council [http://www.sunderland.gov.uk/]
- **Northumberland** – Northumberland County Council, comprising the communities of Bedlington, Ashington, Blyth, Cramlington, Morpeth, Alnwick, Berwick, East Tynedale and West Tynedale. [http://www.northumberland.gov.uk/]

Northumbria operates a devolved model of custody provision in that custody policy is set centrally within the Criminal Justice Department but the actual provision of service, ownership and supervision of staff, etc., falls to the BCU Commander with territorial responsibility for the area where a particular custody facility is located. The link between the policymaking centre and delivery within BCU is provided by five Custody Inspectors (Gateshead and South Tyneside share) answerable to the Custody Chief Inspector within the Criminal Justice Department. It is the intention of the Force to move to a centralised model where all Custody staff are directly answerable to the Criminal Justice Department.

Northumbria Police currently have 259 detention spaces in 14 designated police stations across the Force but maintain 24/7 staffing in only eight as shown in the table below:

Table 2 : Custody Suites in Northumbria

Custody Suite	Area Command	Capacity
Newcastle - Etal Lane*	Newcastle	28
Newcastle – Clifford Street (Byker)*	Newcastle	8
Sunderland – Gillbridge*	Sunderland	20
Washington*	Sunderland	14
Southwick (part time resilience suite)	Sunderland	29
South Shields*	South Tyneside	30
Gateshead*	Gateshead	18
Whickham (part time resilience suite)	Gateshead	10
Bedlington*	Northumberland	20
Hexham (part time rural suite)	Northumberland	7
Alnwick (part time rural suite)	Northumberland	8
Berwick (part time rural suite)	Northumberland	7
Wallsend*	North Tyneside	40
North Shields (part time resilience suite)	North Tyneside	20
Total	**Northumbria Police**	**259**

* Has 24/7 staffing

There are also short term holding facilities at Newcastle United FC and Sunderland FC, but they are not included in this health needs assessment. Further information on the profile of each custody suite can be found in Appendix C.

Custody suites marked as part time are effectively mothballed; rural suites are sometimes used for simple cases as a matter of convenience/efficiency, i.e. to save travel if for the detainee is local and, for example, answering bail for charge only.

In addition to the above, an estates strategy is in place which includes plans for a new 50-cell suite at Newcastle in 2014. This will in part replace the former 24/7 suite at Pilgrim Street (Newcastle) which has recently been closed as not fit for use. A new 40-cell facility opened in North Tyneside in late 2010 and this allowed the North Shields suite to be moved to resilience use (HMIP and HMIC, 2011). Table 2 above shows custody comparison figures for the BCU's and the various stations which constitute the Custody estate. It will be seen that although Pilgrim Street and North Shields figure prominently in the table prior to their removal from 24/7 use, the other part time suites in total represent only 5% of the detainee population.

3.2 Staff Interviews in the Six Command Areas

Approximately 50 interviews (for a full list of those interviewed see Appendix D) were undertaken with a range of police and healthcare staff across the county. Themes arose concerning the health-related features of custody, the aims of healthcare in custody and problems with current healthcare delivery. We have added a final section 'commissioning for healthcare delivery' where we outline some early implications for future NHS commissioning based on these interview data.

Health-related features of the Custody Setting

- To meet health needs acknowledging the transient nature of the context (24-36 hours)
- To recognise that the fundamental role of custody is to process those suspected of offending
- To provide healthcare for a group that have a distinctive socio-demographic profile (and associated lifestyles) that often means that:
  - Detoxification will be required (from either drugs or alcohol or both)
  - Prescriptions will be sought from suitably qualified medical staff
  - Those with personality disorder and self-harm will frequently present
  - Those with mental health problems and learning disabilities will frequently present
  - First aid may be required as will the recognition of, and response to, to medical emergencies such as diabetic hypo-glaecemia

The general health features of custody populations are outlined above and these pertain to all six command areas (more systematic data on the health features of the custody population will be described in Module 2). However, there are specific issues that feature more often in certain districts. One example would be the misuse of benzodiazepines (with or without alcohol) in Gateshead and in Sunderland. In contrast in Bedlington, self-harm was cited as especially problematic.

The Aims of Healthcare in Custody Settings

Themes derived from the interviews indicated that the general features of healthcare in a custody setting (outlined above) lead to the development of general healthcare objectives in custody:

- To identify the nature of a health problem through risk assessment and interview, and to sign-post to existing services (such as drug arrest workers, FMEs and community mental health nurses)
- To patch-up and mend minor injuries
- To refer to medical staff:
  - When 'fitness for interview' or 'fitness for detention' needs to be assessed
  - More serious health problems are suspected
  - Prescriptions might be needed
- To have a policy for dealing with medical emergencies (use of paramedics for example) and to maintain the skills of custody officers in dealing with these, e.g. resuscitation
- To administer prescribed medication as determined by a responsible medical officer
- Monitoring changes in health status whilst in custody and responding to any changes (such as detoxification, stress and pre-existing mental health conditions and self-harm)

Problems with Current Healthcare Delivery

The interviews also revealed the following current problems with healthcare delivery in custody:

- Police custody staff and detention officers take on roles for which they receive little regular training and no on-going supervision such as the administration of prescribed medication.
- There is a largely FME-based system which can lead of waits of up to four hours which slows down custody throughput (leading to periods of unwarranted detention for detainees) and which causes unnecessary anxiety and stress for custody staff
- The current FME contract does not address quality assurance, audit or clinical governance
- There is a lack of data communication between custody and FME records. Custody records are loaded automatically onto a data-base, whilst FME records are on paper only. Thus, information-sharing between relevant agencies is problematic
- The Police Authority is responsible for healthcare delivery and designs many healthcare policies and procedures seemingly without reference to healthcare expertise
- It is the custody sergeant's responsibility to assess risk when a detainee is booked in. Very often they are making health risk assessments without the proper expertise
- The healthcare system in custody is often abused by detainees who if regular attendees understand that, under PACE, it is their right to see a health care professional. In this regard, a comment made by a detention officer is worth quoting 'custody healthcare is open access to priority healthcare'

Commissioning for Improved Healthcare

It is clear from the interviews held with custody and detention staff and also health care staff currently working within the custody environment that a new commissioning specification should adopt certain new principles, as follows:

- There should be a greater skill mix in custody as many tasks currently undertaken by FMEs could, with appropriate training, be undertaken by other healthcare professionals such as nurses
- Systems for NHS audit, quality improvement and clinical governance would be in place with systems for staff clinical supervision would be routine
- One possible option might be for nurses to provide continuous health cover in custody during the day with FMEs providing out of office hours cover. However, there are other options that might be explored
- A continued presence in custody would allow for more efficient: medication management (and possibly prescription); an immediate response for minor injuries and medical emergencies; advice to detention officer supervising drug and alcohol withdrawal; better co-ordination of outside healthcare/drug services; and a clinical suite kept up-to-date and with improved infection control (see HMIC report, 2011)
- The model above would also have a number of advantages from the police's point of view: there would be less anxiety about serious health issues when they present in custody (and less health-related untoward incidents); detention officers would no longer have to administer drugs; health advice would

be at hand; detainees would not have to spend more time in custody than is needed (throughput would be increased); and with improved service co-ordination the risk attached to the police's 24-hour responsibility to detainees post release would be diminished

Module Two: Analysis of Detainees' Health Problems and Services Received

Data linkage: FME Involvement with Detainees

Method:

The original intention had been to obtain a random sample of 2,812 detainees stratified by command area (Newcastle, North Tyneside, South Tyneside, Bedlington, Gateshead and Sunderland) and by year (2010, 2011). This proved problematic for several reasons but basically the custody records were not available when we sought to retrieve them. Ultimately a random sample of 1,917 was achieved which represented 68% of the original sample that was targeted (see Table 3).

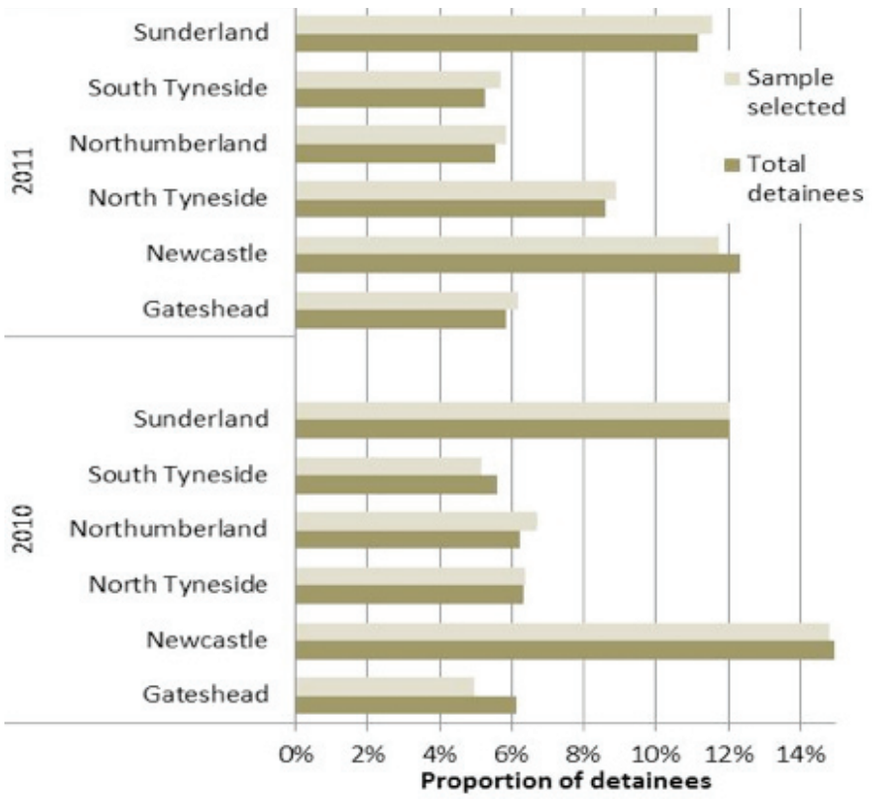
The aim of the data linkage exercise was to relate characteristics of the detainees (age, sex, postcode, charge, risk assessment, location) to the FME health records which should have given information about the reason for a call-out, the problem assessed, and the subsequent intervention. Currently, the FME data is not held electronically but is placed into the detainee's file as a paper record. The report that follows therefore relates to a stratified random sample of detainees, 2010-2011 (n= 1,917). However it should be noted that in 58% of cases no reason was given on the FME record for the call out.

Table 3: Target sample and sample achieved

Area Command	Total Files in Sample	Total Files Accessed	Total Files Missing
Gateshead	312	207	105 (33.7%)
Newcastle	749	374	375 (50.1%)
N. Tyneside	429	330	99 (23.1%)
Northumberland	353	199	154 (43.6%)
S. Tyneside	305	285	20 (6.6%)
Sunderland	664	522	142 (21.4%)
TOTAL	**2,812**	**1,917**	**895 (32%)**

The features of the sample were checked against the population data set of custody records, and despite, our loss of 32% of the target sample there was a close correspondence (Figure one).

Figure 1: Random sample of detainees compared to the population



Analysis: The data were analysed using SPSS 19 using descriptive statistics and a multiple logistic regression in order to determine the odds ratio of the significant factors that predict seeing an FME whilst being held in custody.

Results

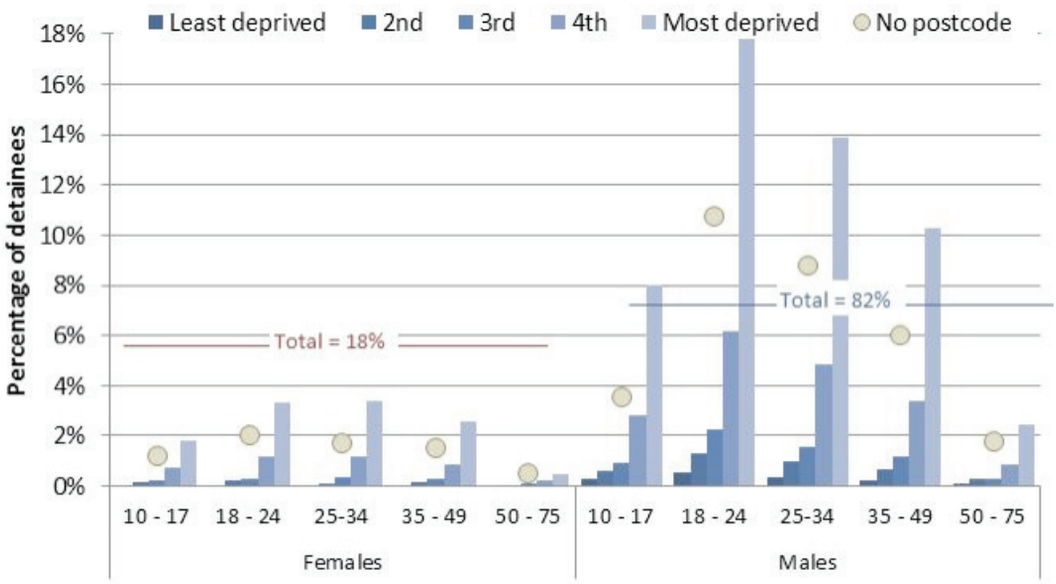
1. Overall descriptions of detainees

a) Basic demographics

- Over the two years 2010 and 2011, there were around 137,000 detentions at Northumbria custody suites
- Of these, 82% were males and 18% female
- 38% did not have a postcode of residence recorded, and could therefore not be allocated to a deprivation quintile
- Of those with a postcode, 64% were living in the most deprived fifth of areas and a further 22% in the 4th most deprived areas. Very few arrests were from affluent areas
- 61% of detainees were aged 18 – 34, with 14% aged 10-17 and just 5% aged over 50

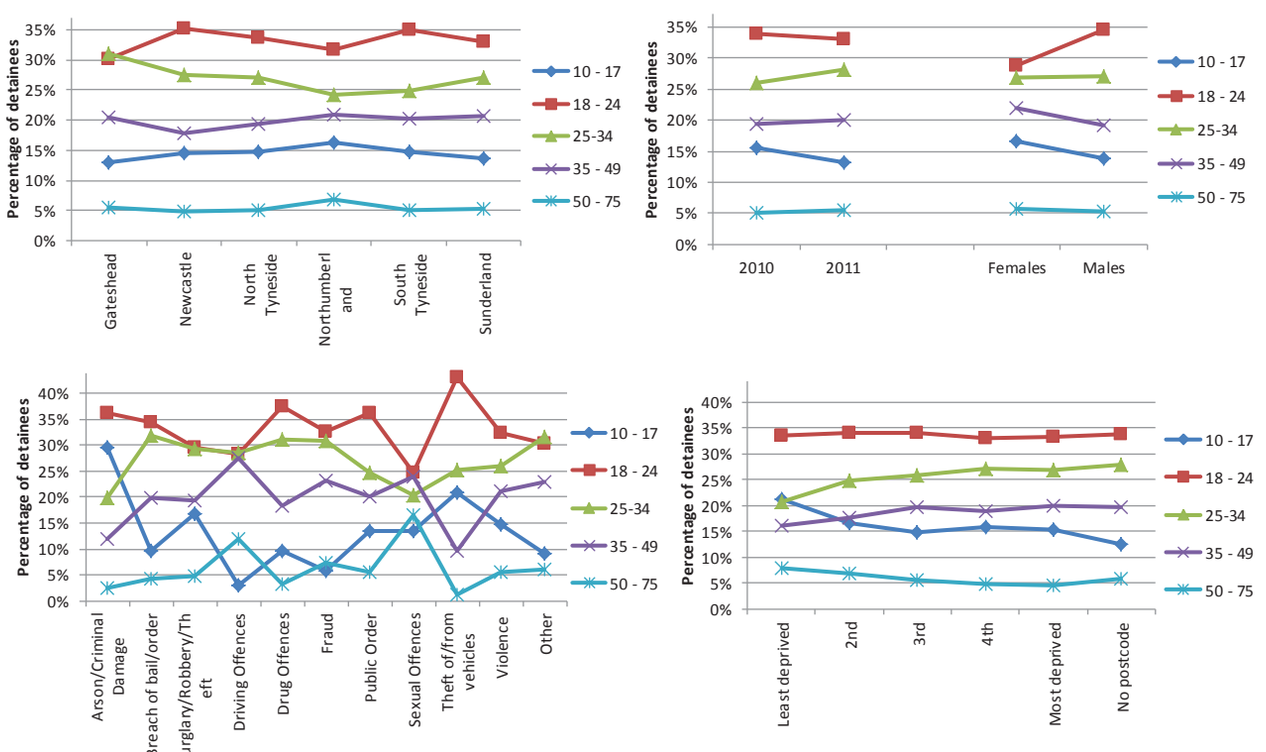
These data are summarised below in Figure 2.

Figure 2: Demographics of all detainees in custody suites across Northumberland, 2010 and 2011 (n = 137,027)



2. What's the influence of age?

Figure 3: Basic demographics by age of detainees in custody suites across Northumberland, 2010 and 2011

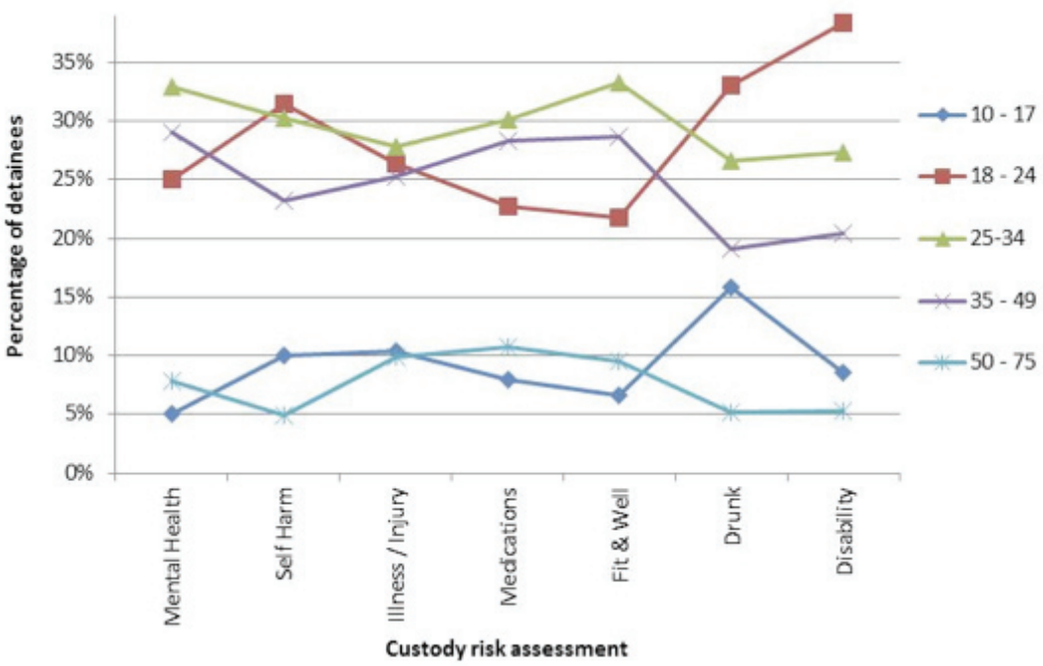


- The age distribution of detainees did not vary greatly across command area, year or deprivation quintile (although those living in the most affluent areas were slightly more likely to be aged 10-17)

- However, age did vary by charge; so those arrested for:
  - arson/criminal damage were more likely to be aged 10-17
  - theft of/from a vehicle were more likely to be aged under 24 (10-17 and 18-24)
  - driving offences and sexual offences were more likely to be aged 50-75
  - Custody risk assessment also varied by age, with those assessed as drunk or with mental disability being more likely to be younger (aged 10-17 and 18-24)

Figure 4 below shows the relationship between detainee's age and the custody risk assessment. The group aged 18-49 scored highly on most of the risk factors whilst those aged either 10-17 or 50-75 scored lower apart from being 'drunk' was highly rated for the younger age group.

Figure 4: Custody risk assessment by age of detainees in custody suites across Northumberland, 2010 and 2011



Sample framework
The CRN records were stratified by detainee age, year and deprivation quintile[1] and a random sample selected within this framework for retrieval of FME records. The stratified sample was compared across custody suites to ensure the same distribution as all
Detainees (see Figure 1 above).

3. What proportion of arrests requires an FME call out and what influences the likelihood of a detainee seeing an FME?

[1] This was derived by linking the detainees postcode (Office for National Statistics, 2012) to the national Index of Multiple Deprivation (Communities and Local Government, 2008) at the Lower Super Output Area geographic level

Figure 5: Proportion of detainees seen by an FME and retrieval of files by basic demographics

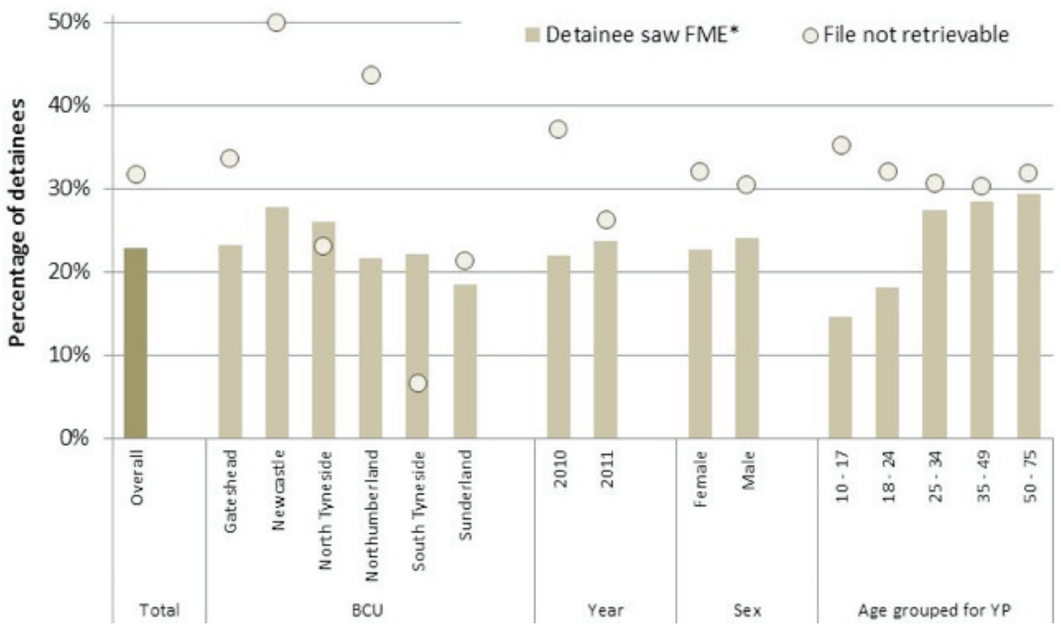
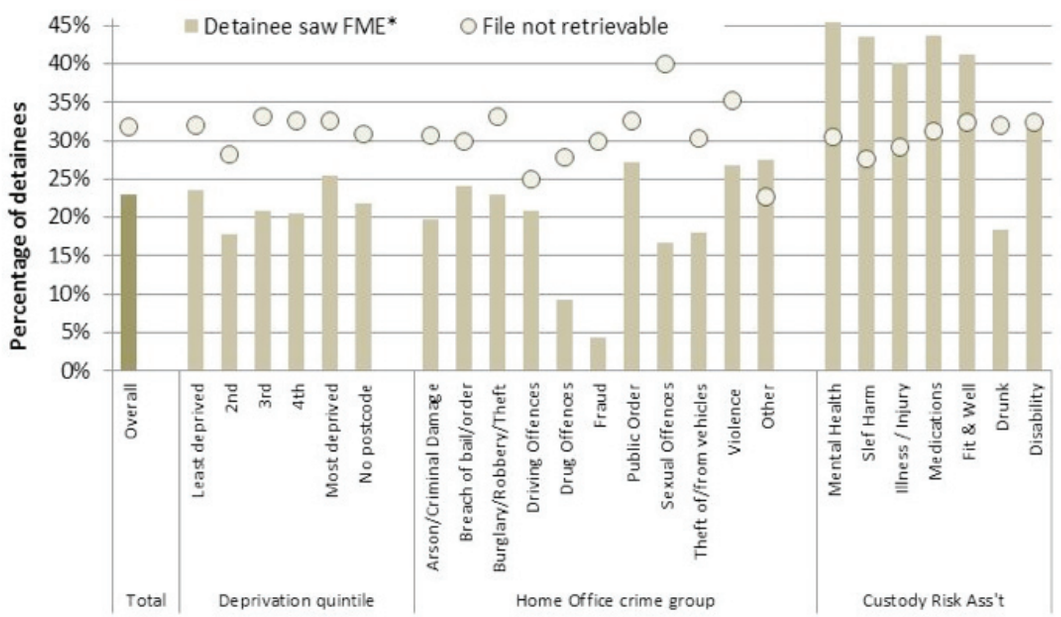


Figure 6: Proportion of detainees seen by an FME and retrieval of files by other potential predictors



- Overall 32% of files could not be retrieved (Fig 5). This was extremely variable by:
  - BCU - with 50% of Newcastle and 44% of Northumberland files not retrieved; the most files retrieved were in South Tyneside
  - Year - later records (2011) had better retrieval rates older ones.
- Of records retrieved, overall, 23% (441/1,917) of detainees were seen by an FME (Fig 5).
- Although slightly variable across basic demographics, only age showed significant influence on the likelihood of seeing and FME (Table 4); people aged 25+ were much more likely than younger people to see an FME.

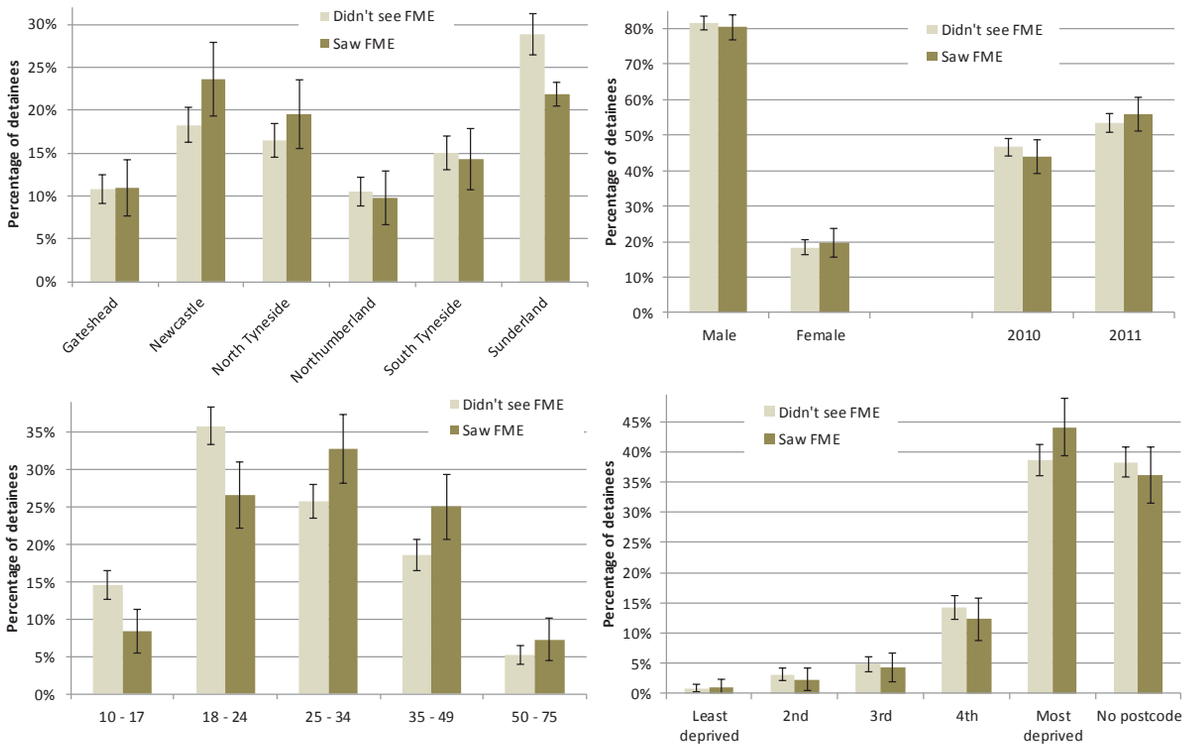
- Of other possible predictors:
  - deprivation did not influence the likelihood of seeing and FME;
  - people arrested for fraud or drug offences were significantly less likely to see an FME; and
  - people arrested for public disorder were significantly more likely to see an FME (Table 4).
- Positive responses to the Custody Sergeant's risk assessment were by far the biggest predictor of seeing an FME, even for those responding 'Yes' to being Fit & Well! Only those recorded as drunk were less likely to see an FME.

Table 4: Summary of detainees seen by an FME and retrieval of files, with logistic regression statistics

				Liklihood of seeing FME				
Variable	Sub-group	File not retrievable	Detainee saw FME*	Odds ratio	B	S.E.	Wald	Sig.
Total	Overall	9.3%	23.0%					
BCU	Gateshead	0.0%	23.2%	Base			14.280	0.015
	Newcastle	4.6%	27.8%	1.371	0.322	0.204	2.491	0.121
	North Tyneside	13.6%	26.1%	1.24	0.211	0.210	1.009	0.306
	Northumberland	36.0%	21.6%	0.942	-0.060	0.241	0.063	0.806
	South Tyneside	2.7%	22.1%	1.005	0.007	0.220	0.001	0.982
	Sunderland	1.1%	18.4%	0.782	-0.246	0.202	1.489	0.224
Year	2010	15.8%	22.0%	Base				
	2011	2.8%	23.8%	1.067	0.066	0.111	0.351	0.554
Sex	Female	11.0%	24.1%	Base				
	Male	8.9%	22.7%	1.081	0.076	0.140	0.293	0.588
Age-group	10 - 15	19.1%	12.3%	Base			34.068	0.000
	16 - 19	7.7%	16.1%	1.294	0.258	0.206	1.564	0.211
	20 - 24	8.1%	19.2%	2.259	0.815	0.204	15.901	0.000
	25 - 34	9.5%	27.5%	2.364	0.860	0.212	16.505	0.000
	35 - 49	7.9%	28.6%	2.422	0.885	0.277	10.228	0.001
Deprivation	Least deprived	10.5%	23.5%	Base			2.583	0.764
	2nd	6.7%	17.9%	0.419	-0.869	0.728	1.427	0.232
	3rd	14.2%	20.9%	0.627	-0.468	0.673	0.483	0.487
	4th	13.4%	20.5%	0.561	-0.578	0.634	0.832	0.362
	Most deprived	10.3%	25.4%	0.673	-0.397	0.618	0.412	0.521
	No postcode	6.0%	21.9%	0.637	-0.451	0.619	0.531	0.466
Home Office crime group	Arson/Criminal Damage	8.1%	19.7%	Base			13.9	0.178
	Breach of bail/order	10.6%	24.1%	1.319	0.277	0.296	0.876	0.349
	Burglary/Robbery/Theft	8.6%	22.9%	1.246	0.22	0.266	0.687	0.407
	Driving Offences	5.3%	20.8%	0.943	-0.059	0.394	0.022	0.882
	Drug Offences	9.1%	9.2%	0.521	-0.652	0.392	2.775	0.096
	Fraud	4.1%	4.3%	0.293	-1.226	0.773	2.519	0.112
	Public Order	8.9%	27.2%	1.138	0.13	0.255	0.257	0.612
	Sexual Offences	17.2%	16.7%	0.862	-0.148	0.613	0.059	0.809
	Theft of/from vehicles	4.9%	17.9%	1.328	0.284	0.5	0.322	0.571
	Violence	13.1%	26.7%	1.437	0.362	0.278	1.694	0.193
	Other	6.5%	27.6%	1.342	0.294	0.41	0.516	0.473
				Base = overall total				
Custody Risk Ass't	Mental Health	9.7%	45.5%	1.835	0.607	0.157	14.91	0
	Self Harm	8.0%	43.6%	1.689	0.524	0.152	11.926	0.001
	Illness / Injury	8.7%	40.0%	1.685	0.522	0.147	12.545	0
	Medications	9.6%	43.7%	1.168	0.155	0.17	0.829	0.363
	Fit & Well	9.2%	41.2%	2.174	0.777	0.153	25.908	0
	Drunk	9.8%	18.4%	0.497	-0.698	0.147	22.657	0
	Disability	8.0%	32.8%	1.674	0.515	0.151	11.69	0.001

Are there any differences between those requiring an FME and those that do not?

Figure 7: Proportion of detainees seeing an FME or not by basic demographics



Compared with those not requiring a FME, detainees requiring a FME (Figs 7,8,9) were significantly:

- Less likely to be held at Sunderland
- More likely to be aged 25+ and less likely to be younger
- Less likely to have been arrested for drug offenses or fraud
- More likely to have responded positively to the Custody suite assessment for all conditions except being drunk

There were no differences in sex, year detained or deprivation between those requiring a FME and those not.

Figure 8: Proportion of detainees seen by an FME or not by Home Office crime category

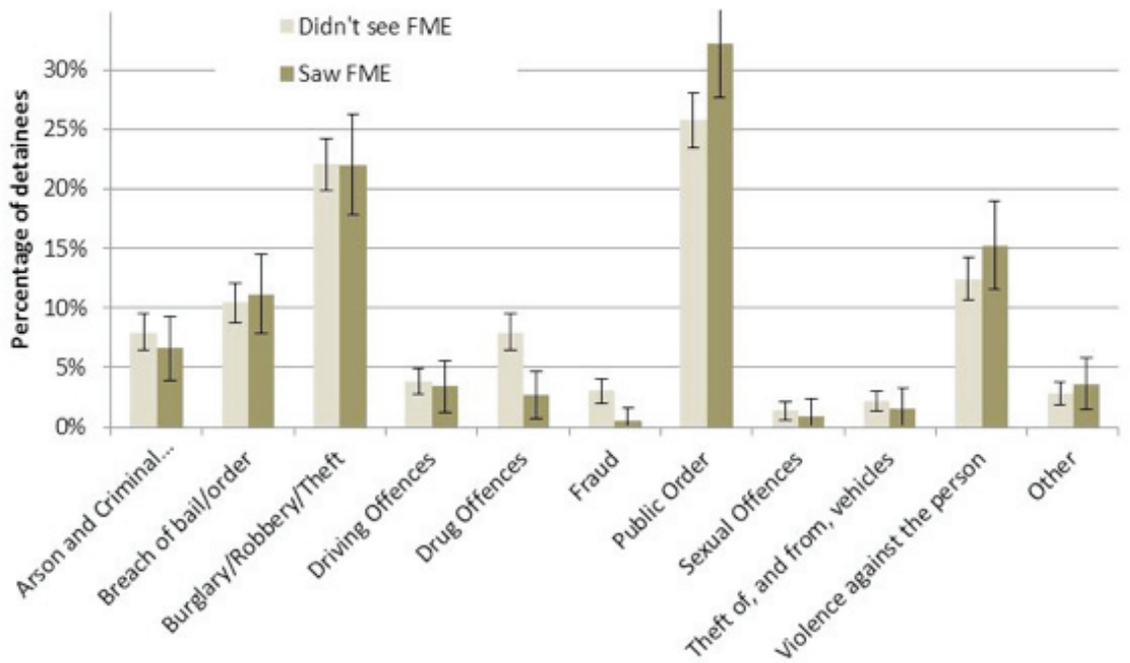
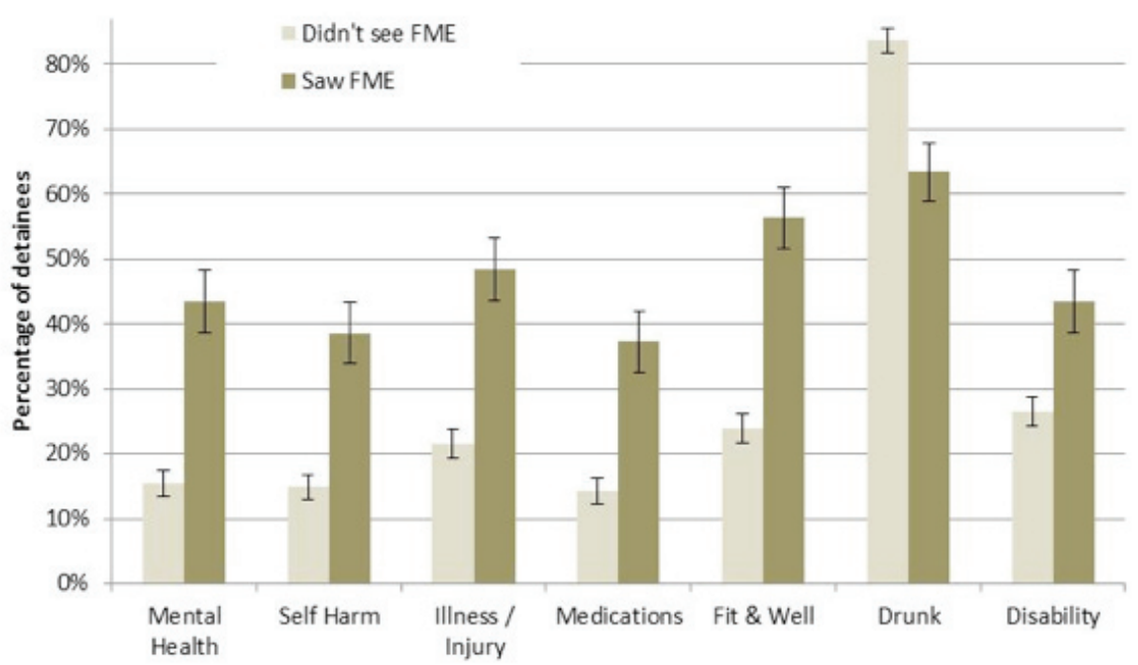


Figure 9: Proportion of detainees seen by an FME or not by positive response to Custody assessment



4. For the 'FME call-out' group, what was the main reason for call out?

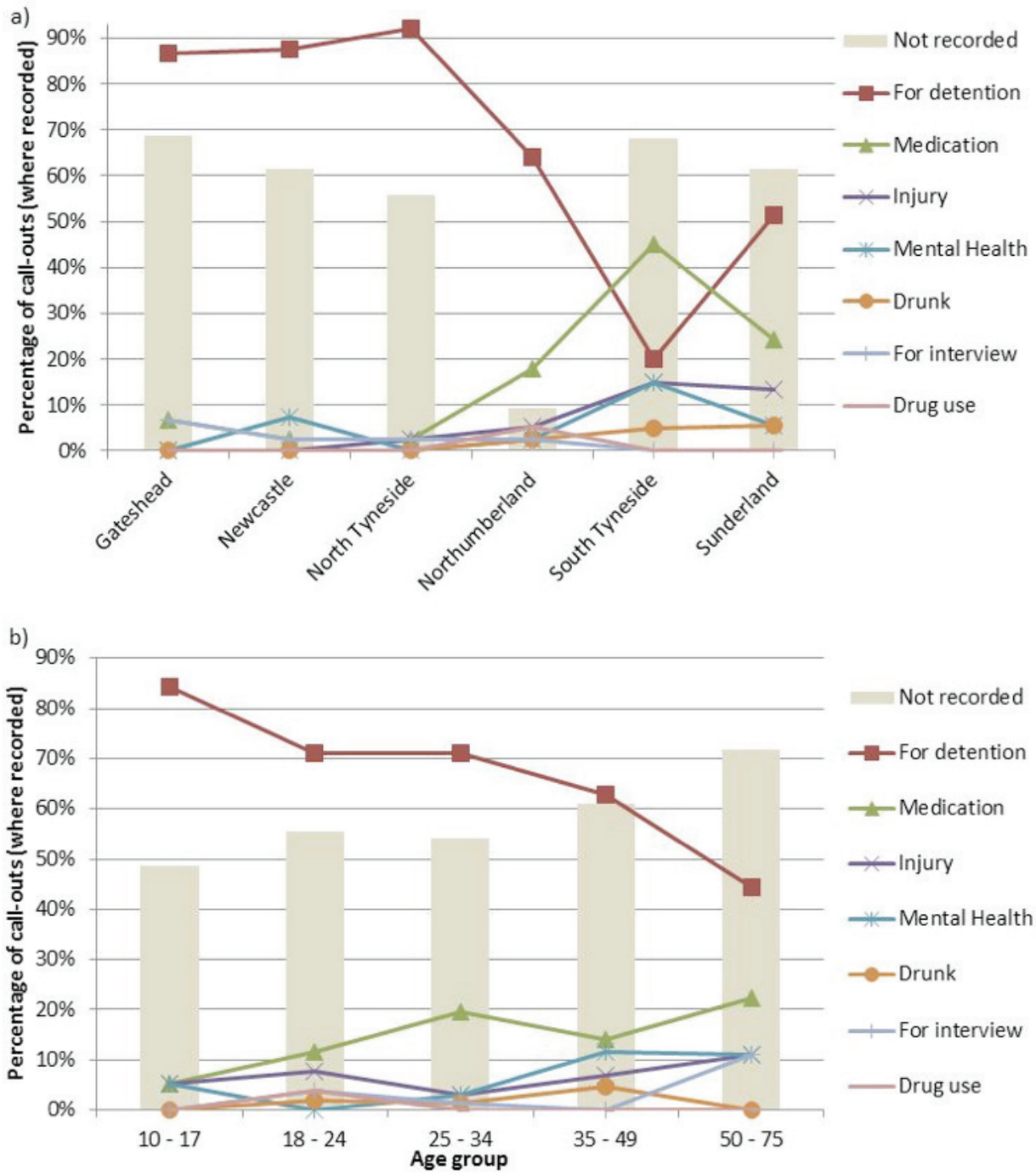
Table 5: Summary of reasons detainees saw an FME and the main reason for the call out

	Reason for FME call out...						
Measure	For detention	For interview	Medication	Injury	Mental Health	Drunk	Drug use
Number	131	51	40	25	21	15	6
% (inc multiple reasons*)	69.3%	27.0%	21.2%	13.2%	11.1%	7.9%	3.2%
Main Reason (%)	69.3%	2.1%	14.8%	5.8%	4.8%	2.1%	1.1%

Do **not** sum to 100% due to multiple reasons

- Overall, 57% of records (n = 251 / 441) had no reason for the call out recorded
- Of those with a reason recorded, the main reason for call out was to assess if the person was fit to be detained. However, 41% of records have more than one reason recorded (31% had 2 reasons, 7.4% had 3 reasons and 3.2% had 4 reasons).
- Where there were multiple reasons, the main reason was selected in this priority order: fit for detention, fit for interview, medication, injury, mental health, drunk, drugs (i.e. in order of being listed on the form). This altered the order of reasons for call-out so that medication was the second reason, followed by injury and mental health.
- The proportion of records with no reason for call-out varied significantly by command area, with Northumberland having less than 10% not recorded but Gateshead and South Tyneside having nearly 70% not recorded.
- For those with reasons recorded, there was also much variation with reasons other than for detention being much more likely in Northumberland, South Tyneside and Sunderland.
- Also, reasons other than for detention were increasingly more likely to be recorded as the detainee age increased.

Figure 10: Reasons for being seen by an FME, including proportion where reasons not recorded, by a) Command Area and b) age



In the interpretation of the data in Figure 10 above it should be borne in mind that the custody sergeant decisions about FME call-out do vary substantially by area command.

5. Does FME assessment match the Custody assessment?[2]

Table 6: Relationship between the FME assessment and the main reason for call-out

	Main reason for call-out…								
FME assessment	Drunk	Drug use	For detention	For interview	Injury	Medication	Mental Health	Not recorded	Total
detainee misuses alcohol	100.0%	50.0%	48.8%	25.0%	50.0%	25.0%	33.3%	47%	46.3%
assesses fitness for detention/interview	75.0%	0.0%	43.4%	25.0%	20.0%	28.6%	55.6%	44%	42.4%
detainee already on prescriped meds	0.0%	0.0%	30.2%	25.0%	20.0%	39.3%	22.2%	28%	28.9%
gives/recommends medication	50.0%	50.0%	27.9%	0.0%	30.0%	32.1%	11.1%	24%	25.7%
notes/assesses/treats injury	0.0%	0.0%	27.1%	25.0%	70.0%	7.1%	0.0%	22%	23.2%
detainee misuses drugs	0.0%	100.0%	20.2%	0.0%	0.0%	21.4%	0.0%	20%	19.0%
detainee has mental health problems	0.0%	0.0%	10.9%	0.0%	10.0%	10.7%	55.6%	21%	17.4%
refers detainee onto another health service	0.0%	0.0%	14.0%	0.0%	40.0%	0.0%	11.1%	5%	8.3%
detainee is in pain	25.0%	0.0%	7.0%	0.0%	30.0%	7.1%	0.0%	7%	7.4%
detainee has used health services previously	0.0%	0.0%	6.2%	0.0%	0.0%	0.0%	55.6%	7%	7.1%
detainee is emotional	0.0%	0.0%	3.9%	0.0%	0.0%	0.0%	0.0%	6%	4.8%
detainee has epilepsy	0.0%	0.0%	3.1%	0.0%	0.0%	3.6%	0.0%	6%	4.4%
assesses risk of self-harm or suicide	0.0%	0.0%	4.7%	0.0%	0.0%	0.0%	0.0%	4%	3.7%
detainee has asthma	0.0%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	2%	2.1%
detainee has diabetes	0.0%	0.0%	0.8%	0.0%	0.0%	3.6%	0.0%	2%	1.8%
calls ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1%	0.5%

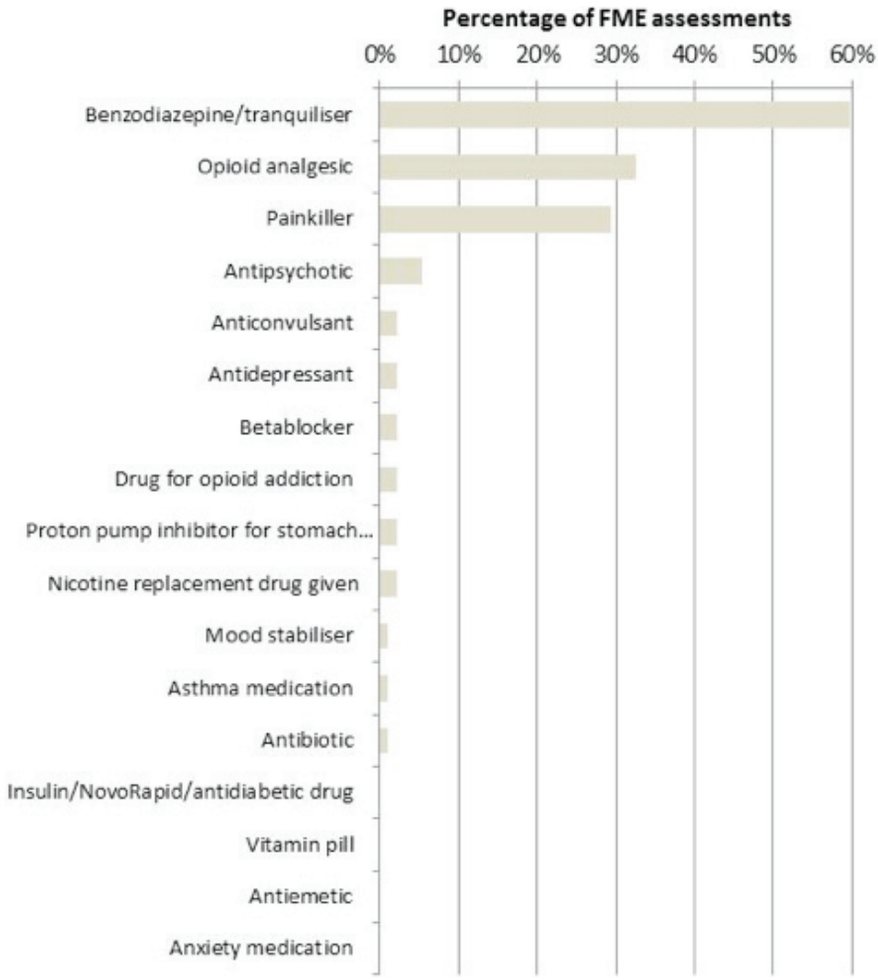
- All (100%) of those responding positively to the custody assessment of being drunk or drug misuse also had an FME assessment of being drunk or misusing drugs.
- Other positive responses to the custody assessment did not necessarily match the FME assessment
- Overall, the main FME assessment related to alcohol misuse and assessing fitness for detention; followed by prescribed medication, giving medication, injury, drug misuse and mental health problems.

6. What was the main treatment?

- There were predominantly three main treatments given following and FME assessment:
  - 60% of detainees were given Benzodiazepine/tranquiliser
  - 33% were given Opioid analgesic; and
  - 30% were given painkillers
- In addition, 5% were given Antipsychotics and all other treatments were provided to less than 3% of detainees

[2]Small numbers preclude inference of statistical significance

Figure 11: Treatments given to detainees undergoing an FME assessment



7. What is the relationship between main reason for call out and nature of treatment?[3]

Table 7: Relationship between the FME treatment and the main reason for call-out

	Main reason for call-out...								
FME Treatment	Drunk	Drug use	For detention	For interview	Injury	Medication	Mental Health	Not recorded	Total
Benzodiazepine/tranquiliser	100%	100%	61%		17%	68%		52%	59.8%
Opioid analgesic		100%	32%		33%	41%		25%	32.6%
Painkiller	33%		25%	100%	83%	27%		25%	29.3%
Antipsychotic			5%			5%	50%	1%	5.4%
Anticonvulsant			2%			5%		8%	2.2%
Antidepressant			4%					5%	2.2%
Betablocker			2%			5%		1%	2.2%
Drug for opioid addiction			4%					4%	2.2%
Proton pump inhibitor for stomach acid/ulcer			4%					1%	2.2%
Nicotine replacement drug given	33%		2%					3%	2.2%
Mood stabiliser						5%		2%	1.1%
Asthma medication			2%					1%	1.1%
Antibiotic			2%					3%	1.1%
Insulin/NovoRapid/antidiabetic drug								2%	0.0%
Vitamin pill								3%	0.0%
Antiemetic								1%	0.0%
Anxiety medication								1%	0.0%

[3]Small numbers preclude inference of statistical significance

- In all cases, regardless of the reason for call-out, the main treatments were tranquiliser, analgesic or painkiller

Conclusion for Analysis of Custody Records/FME Record Linkage

Conducting this section of the health needs assessment revealed difficulties with both accessing custody records for the random sample taken, and (in cases where the detained person had seen a FME), for ascertaining from the record the reason why a FME was called out. All in all the data pertaining to reason for FME call out should be treated with some caution as in 58% of the accessed records no reason was given for FME call out.

Analysis of custody data and data from FME forms showed that the majority of detained persons were young males living in deprived areas. Examination of basic demographic variables revealed that only age showed significant influence on the likelihood that a detained person would see a FME. Furthermore, detainees responding positively to any of the custody sergeant's risk assessment questions apart from being drunk were more likely to see a FME than those who did not. It should be noted though that being 'drunk' is a very wide catch all category and the custody sergeants frequently err on the side of caution when making this assessment. The most frequently recorded reason for a FME being called out was to assess fitness for detention. However, 41% of records which gave a reason for an FME callout listed more than one reason. Data from FME forms were compared to those from Custody Sergeant's assessments of detainees. This revealed a hundred percent agreement between these two data sources in relation to custody sergeant's assessment, and the FME's assessment and treatment, when the detainee had been misusing alcohol or drugs.

Case Studies

In the data linkage exercise report above it was not possible to determine the number of offences committed by any one individual because each new arrest generates a new custody record. It was, however, strongly suspected that more prolific offenders would be greater consumers of custody-based healthcare. It was agreed, out with the original contract specification, that a number of case studies would provide a more detailed examination of this relationship. All custody records were thus requested for the two most prolific offenders in each of the six command areas. The 12 vignettes below are the result of analysis of these files.

Please note that each bullet point below relates to one arrest.

Case Study - Ms A
A 22 year old woman with 19 arrests between 2011/2012. All the offences were for shop-lifting and she was on a drug rehabilitation community supervision order. She had two contacts with an FME as follows:

- Painkillers prescribed for broken toes (incurred whilst intoxicated)
- Stomach cramps reported in the context of two month pregnancy but no further action

Case Study – Mr B
A 33 year old man with 33 arrests between 2010/2012 mostly for theft and burglary. He is a heroin addict who regularly takes subutex and valium. On his last arrest he was being treated for an abscess to his shoulder. He has seen an FME a number of times as listed below:

- Prescription given for subutex and valium
- Complaining of pain to his ankle prescribed ibubrofen. FME states that codeine not to be prescribed

- Another call out for this ankle now prescribed valium and dihydrocodeine
- States that he's on a methadone programme and needs valium and is prescribed valium
- FME attends to prescribe methadone
- Informs FME he needs methadone and valium to sleep and is prescribed both
- Girlfriend brings in methadone in an unlabelled bottle, the FME takes this away but prescribes valium and dihydrocodeine

Case Study 3 – Mr C

A 19 year old man with 12 arrests, between 2011/12, all for theft, burglary and breach of bail.

- He informs the FME that he is alcohol dependent and that he buys and sells street valium. He is agitated and restless and is prescribed valium
- Again tells the FME that he is alcohol dependent and is prescribed valium

Case Study 4 – Mr D

A 47 year old man who has been convicted of 147 offences since 1988 he has 11 arrests between 2010/11. He is dependent on heroin and is also addicted to street valium. He is now on methadone. He has a deep vein thrombosis and is also known to conceal weapons and needles.

- Tells FME he is on warfarin (for DVT) and methadone and that he has taken both already that day. He is prescribed valium
- Informs the FME that he is dependent on alcohol and is prescribed valium
- He has had seven teeth extracted earlier on the day of arrest and his mouth is sore. He is prescribed paracatemol and ibuprofen

Case Study 5 - Mr E

A 26 year old man with ten arrests since November 2011. He has been charged with various offences including: theft, burglary; shop-lifting; possession of class A drugs and with the breach of a civil injunction. He takes methadone daily.

- Concerns about rousing him and FME attended and prescribed valium
- Assesses as fit for interview
- Seen for drug and alcohol dependence and prescribed valium
- Prescribed valium
- Arrested in possession assessed as fit for interview
- Intoxicated not fit for immediate interview
- Seen twice by FMEs not fit first interview assessed as fit second visit. Prescribed valium and methadone
- Seen twice by FMEs not fit for interview first assessment but fit for interview seond assessment. Prescribed methadone and valium

- Taken today's methadone assessed as fit for interview
- Assessed by FME, pupils were dilated, given four hours before interview

Case Study 6 – Mr F
A 37 year old with eleven arrests since February 2012 these arrests are mostly for shop-lifting and breach of bail. He is prescribed methadone and valium for epilepsy and states that he has a personality disorder:

- Tells FME he has not had today's methadone, valium or carbamazepine. The FME states that he is a 'chronic liar' with personality disorder and OCD. He was found with a bottle of vodka but states he has only had half a lager. Deemed fit for interview and prescribed carabamzepine, dihydracodeine and valium.
- Alcohol intoxification and facial injury
- States he suffers from anxiety and depression
- Intoxicated and not fit for interview but determined fit for interview at second FME visit some eight hours later. He was prescribed valium and dihydracodeine

Case Study 7 – Mr G
A 28 year old man with 14 arrests since May 2010. The only available records were for five of these arrests, all for burglary.

- On arrest he had taken valium and methadone and smelt of alcohol. Seen by the FME who states that he has a history of self-harm but is fit for interview. He is prescribed valium and dihydracodeine
- Seen by FME and prescribed valium and dihydracodeine
- States he is on valium and dihdydracodeine and is prescribed both
- States he needs 10 mgs of valium for the interview and this is prescribed

Case Study 8 – Ms H
A 30 year old woman with 14 arrests since November 2011 however there are only two custody records both for theft although she has a string of other arrests for falsifying prescriptions.

- Took tablets whilst standing in front of the custody desk. Sent to Newcastle General acute medical unit where it was elicited that she had taken valium and mirtazepam. She was monitored in the unit and referred to psychiatry
- Seen by FME for a substance misuse on subutex not fit for interview at this time. Seen a second time by the FME who prescribed subutex and deemed her fit for interview. Valium was also prescribed. She was seen a third time by an FME to administer the subutex.
- Tells the FME that she has anxiety and depression and the FME prescribes valium and mitrazepam.

Case Sudy 9 – Mr I

A 31 year old man with ten arrests since January 2012. The charges related to being drunk and disorderly, theft, and shop-lifting. He has alcohol problems and states that he has a history of mental health problems.

- Sent to hospital for suturing of a head wound and given five stitches
- Fit for interview although intoxicated on arrest
- Sent to hospital and he claims to have taken 100 mgs of valium along with two pints of strong cider. On return he was seen by FME and prescribed valium.
- Assessed as alcohol dependent and prescribed citalopram, carbamazepine and valium. Seen twice by FME before deemed fit for interview.
- Two assessments by FME he has alcohol withdrawal and is also an epileptic. He is prescribed valium and carbamazepine and seen twice before being assessed as fit for interview.
- Informs the FME that he is on olanzepine, citalopram and propanolol so all three drugs are prescribed.
- Alcoholism, intoxification and possible related fits, he is prescribed valium
- Arrested wearing heart monitor pads and no reason for this can be ascertained.
- Chronic alcohol misuse, seen twice by the FME who declares him fit for interview and prescribes valium and olanzepine.

Case Study 10 – Mr J

A 26 year old man with 10 arrests since August 2010 all arrests related to burglary, supply of drugs and affray.

- He is seen twice by the FMEs, not deemed fit for interview at first but fit for interview six hours later. He is prescribed methadone.
- He is seen and interviewed and states he uses methadone and street valium. He is prescribed valium
- Seen twice by FMEs at the first visit not assessed as fit for interview and prescribed methadone and valium
- Under the influence of drugs when arrested and detention authorised by FME.
- Seen by FME twice on the first occasion valium is prescribed on the second occasion methadone is prescribed.

Case Study 11 – Mr K

A 36 year old man with eight arrests since November 2011 mostly for theft from motor cars.

- Appears tired and sleepy and has taken methadone and street valium but fit for interview
- He is prescribed codeine phosphate and uses alcohol regularly he is prescribed valium and codeine phosphate
- Seen on three occasions by the FME. Initially prescribed paracetamol for back pain. On the 2nd visit he states that he has arterio-sclerosis and a ‘benzo’ habit. He is now prescribed valium, naproxen, paracetamol and mitrazepine.

Case Study 12 – Mr L

Forty five year old man who has been arrested on nine occasions since July 2011. These charges are mostly for shop-lifting although one is for possession of a Class A drug. He is a heroin addict currently on methadone and says he is prescribed valium for 'depression'.

- Seen by the FME, he has generalised arthritis and has also missed today's methadone. He is prescribed methadone, valium, dihydracodeine and paracetemol
- Prescribed dihydracodeine and fit for interview
- Prescribed dihydracodeine and fit for interview
- Prescribed dihydracodeine and valium and fit for interview
- Prescribed dihydracodeine for pain in his hand and fit for interview
- Claims to have angina and depression prescribed valium and glycerol trinitrate
- Asessed as fit for interview call paramedics if any report of chest pain

Case Study: summary

In every case of prolific offending presented above drug misuse is a feature and the majority of offenders are being prescribed methadone. In a significant proportion of the cases methadone prescription is supplemented by both minor tranquilisers (such as valium) and alcohol. The offences committed are all relatively minor and feature shop-lifting; burglary; theft; possession of class A drugs; and breaches of bail. This group of 12 had been arrested at least 161 times in the last year. In relation to custody-based healthcare the FME had been called out on 55 occasions. The reason was mostly for an assessment of fitness for interview and very often the offender was too intoxicated to be interviewed immediately. This left the police managing risk for periods of up to 6 hours. Very often the FME prescribed both valium and di-hydrocodeine. The offender claimed at times to be suffering from physical ill-health, for example, angina, back pain, epilepsy, and angina. Very often the drugs prescribed would have been the drugs the most appropriate for these conditions. Mental health issues were also a feature of the FME assessment. The detainee, for example, claiming to be diagnosed with depression, personality disorder and psychosis. For all conditions, physical or related to mental health, it did not prove possible for the FME to check the veracity of the claims with a GP. Clearly, they saw their role as managing the risk that presented.

Module 3: Detainees views of healthcare

A total of 327 detainee surveys were completed in a two-week period March-April 2012. Each area command across the region was represented as follows:

- Gateshead: 21, (6.4%)
- Newcastle: 104, (31.8%)
- Northumberland: 76, (23.2%)
- North Tyneside: 41, (12.5%)
- South Tyneside: 38, (11.6%)
- Sunderland: 47, (14.4%)

It would have been anticipated that there would have been approximately 1,350 arrests in any given week so the number of completed questionnaires represented about 12% of all those arrested in the two weeks where questionnaires were distributed.

Examination of the demographic characteristics of the detainees completing the survey showed that 261 (79.8%) of respondents were male, and 63 (19.3%) were female. The sex of three respondents was not recorded in the surveys. The mean age of respondents was 29.3 years (s.d. = 12.0), and the median age was 25 years.

When asked whether they had any concerns about any aspect of their health whilst they were in custody, 58 (17.7%) of respondents replied that they did have a concern, 266 (81.3%) of respondents replied that they did not have a concern, and 3 (0.9%) of respondents did not answer this question.
The 58 detainees who stated that they had a health concern whilst in custody were asked to provide details of this concern. These fell into six main areas:

a) Self-harm/suicide: n=2, (0.6%) of all respondents, 3.4% of those with a health concern

b) Drug misuse: n=7, (2.1%) of all respondents, 12.1% of those with a health concern

c) Alcohol misuse: n=7 (2.1%) of all respondents, 12.1% of those with a health concern

d) Mental health: n=5, (1.5%) of all respondents, 8.6% of those with a health concern – three respondents with concerns about depression, and one with a concern about claustrophobia, and one with a concern about anxiety

e) Medication: n=10, (3.1%) of all respondents, 17.2% of those with a health concern – four respondents recording methadone as a concern, two with a concern about diazepam (one of which was also concerned about subutex), and two who needed painkillers. The remaining two responses in this group stated ‘getting meds for my problems’ and secondly “complaining FME did not prescribe enough meds’ in his words ‘I was ripped off’”

f) Injuries: n=10, (3.1%) of all respondents, 17.2% of those with a health concern

There were various other health concerns relating to epilepsy, general health, asthma, stress, emotional upset at arrest, and periods. In addition, one respondent noted that they had previously had a kidney transplant, and was not on medication, and two respondents stated that they had been assaulted by the police. Finally, two surveys stated that the respondents had been seen by an FME and paramedics.

When asked whether they were offered any help for a health problem whilst in custody, 138 (42.2%) of respondents stated that they were, and 183 (56%) of respondents stated that they were not offered help. The remainder (n=6) did not answer this question. Further examination of these responses shows that of the 58 respondents with a concern about an aspect of their health, 53 (91%) were offered help with a health problem whilst in custody. In addition, 84 (32.1%) of the 262 respondents who did not have any health concerns of their own whilst in custody were also offered help.

Finally, respondents were asked to rate the extent to which any help that they were offered met their needs on a five-point likert scale ranging from ‘not at all’ to ‘fully’. As stated above, 138 respondents stated that they had received help with a health problem whilst in custody. Of these, 132 respondents rated the help that they had received on the likert scale. 73 (55.3%) of these 132 respondents stated that their needs had been fully met, 27 (20.5%) that their needs were ‘mostly’ met; 15 (11.4%) that their needs were ‘somewhat’ met; 9 (6.8%) that their needs were met ‘a little’, and 8 (6.1%) that the help that they were offered did not meet their needs at all.

Module 4: Analysis of complaints, adverse incidents and self-harm

Complaints

The following information was extracted from the Centurion database using the Xanalys programme by CV 4360 Edgar. Complaints cases were only extracted where allegations were made relating to medical issues. The analysis covered the period April, 2010 until March 2012. Over that period there were 24 health related complaints or one per month. The rate of health complaints is therefore extremely low at 1 per 5,800 arrests. The types of alleged health incidents can be grouped under the following headings:

- Not offered sufficient exercise
- No immediate attention for injuries and wounds
- Refusal of access to a Doctor
- Lengthy waits for medical attention
- Medication being denied
- Insufficient food and drink provided

The complaints are investigated independently and ten were not upheld, four were resolved locally, three are live, two were withdrawn, two were given dispensation, one is sub judice, one is still in the appeal period, and one complaint was upheld. Here one individual claimed that she was not provided with proper medical care following arrest. No further details are given.

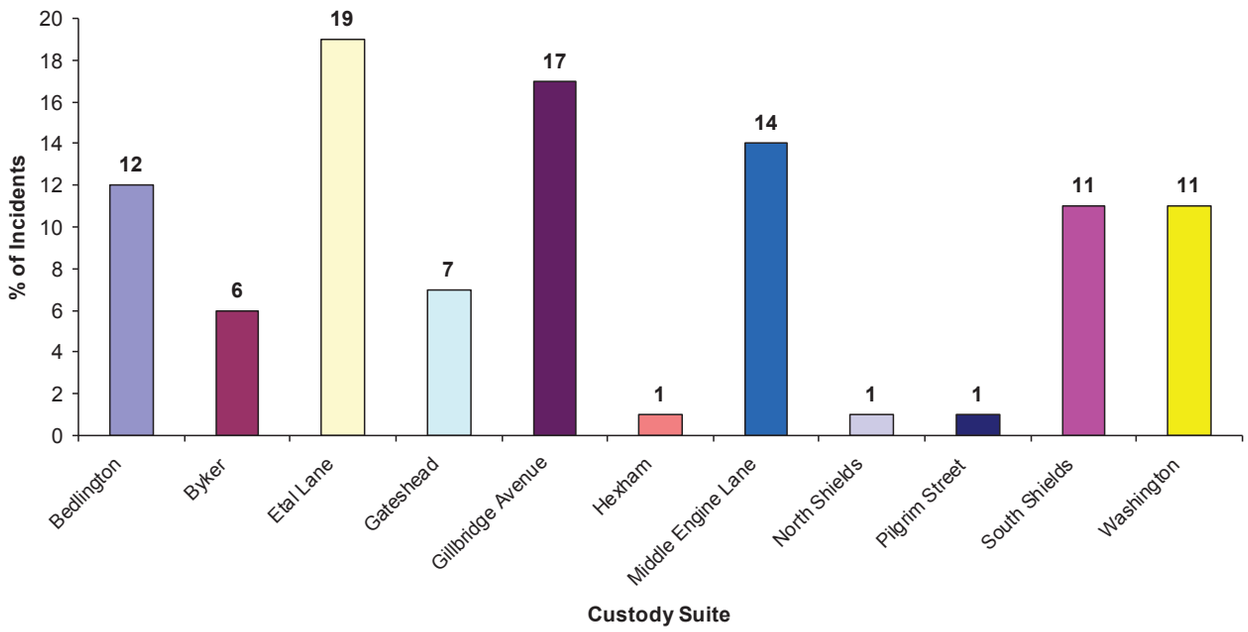
Adverse Incidents

Adverse incidents are defined as follows:

> *'An adverse incident is any incident, if allowed to continue to its ultimate conclusion, would have resulted in death or serious injury but for an intervening factor or the actions of an individual which prevented those consequences.*
>
> *Where an adverse incident occurs either on police premises or elsewhere, the Duty Inspector will be informed immediately and will make an initial assessment of the circumstances'*

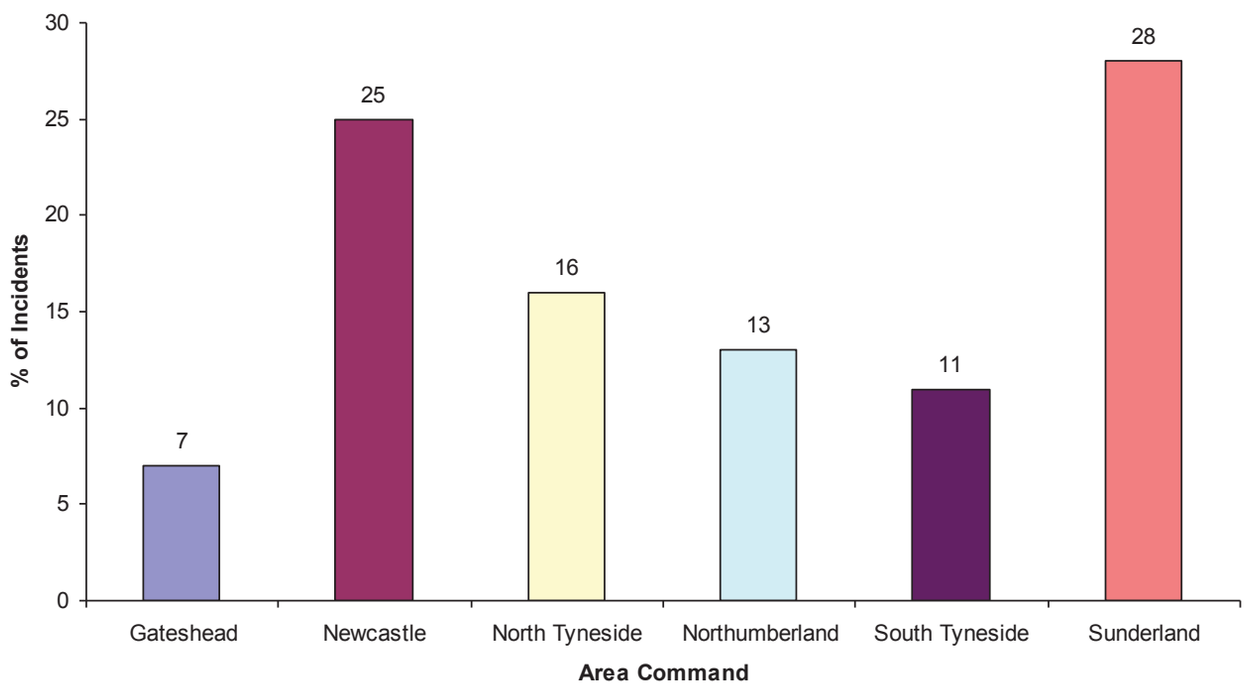
Every fourth adverse incident was investigated until a total of 100 cases was reached. Initial analysis of these data showed that the percentage of incidents split across the different custody suites as follows:

Figure 12: Adverse Incidents by Custody Suite



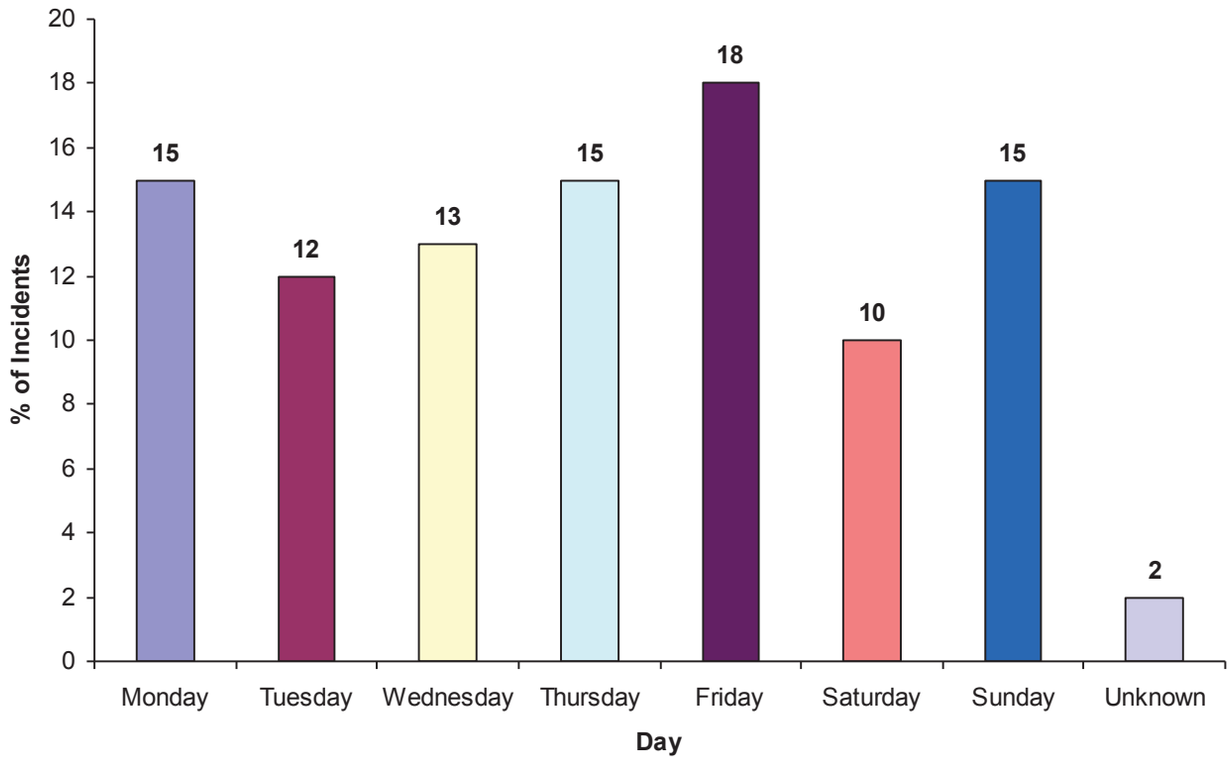
Analysis by Area Command revealed that the largest proportion of incidents occurred at within the Sunderland and Newcastle areas (see Figure 13 below).

Figure 13: Adverse Incidents by Area Command



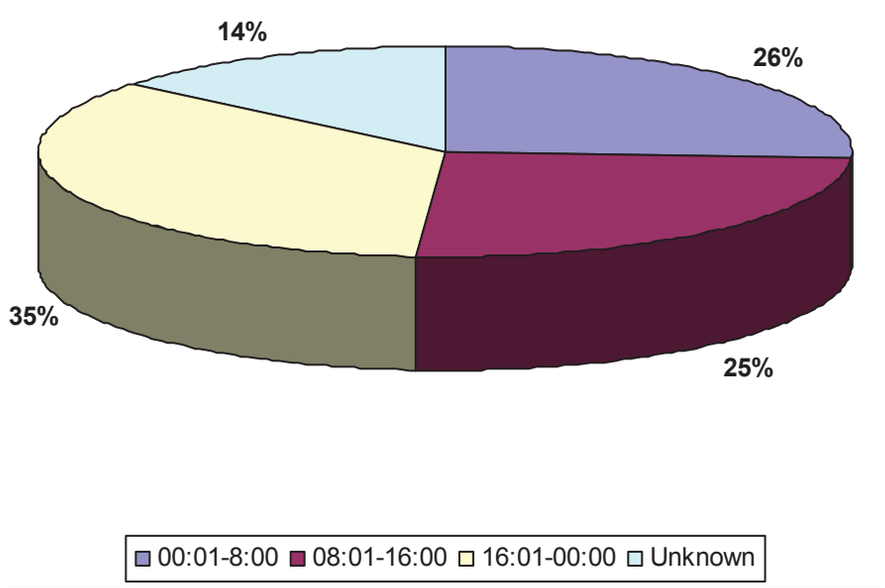
Examination of the days of the week upon which the adverse incidents occurred revealed a fairly even split across the week, with the largest proportion of incidents occurring on Fridays (see Figure 14 below).

Figure 14: Days upon Which Adverse Incidents Occur



The times at which the adverse incidents occurred were divided into eight-hour blocks. As shown in Figure 15 below, analysis of these data showed that incidents were most likely to occur between 16:01 and midnight. However, it should be noted that the time at which the incident occurred was not recorded in 14% of the cases examined.

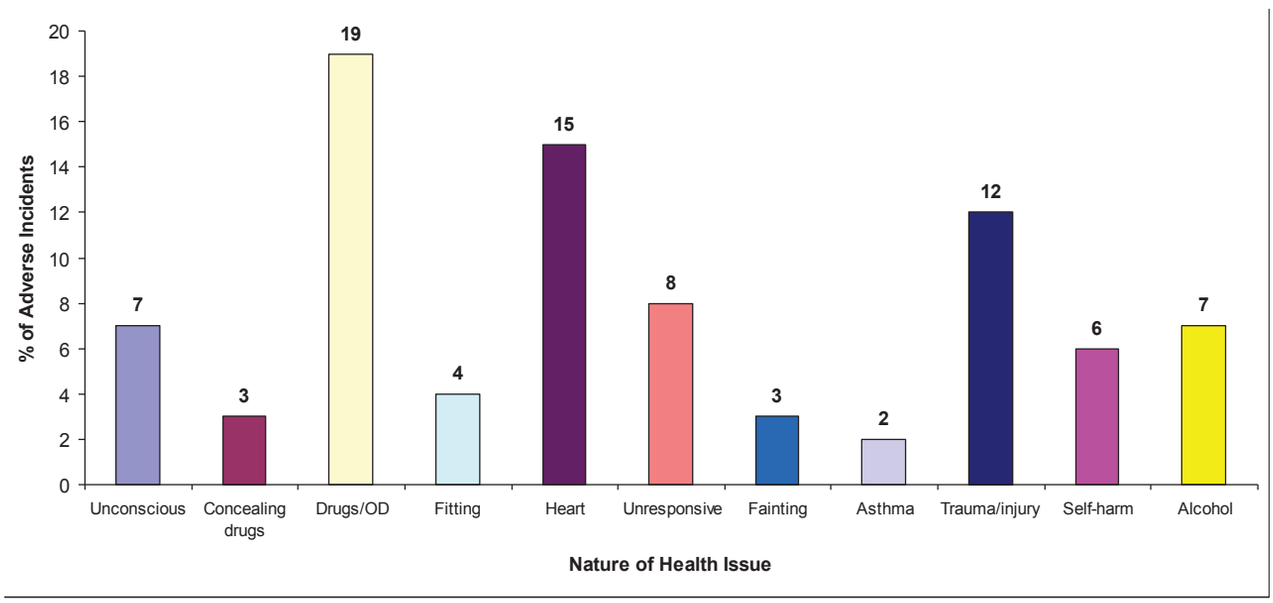
Figure 15: Times at Which Adverse Incidents Occurred



All of the adverse incidents were coded according to the primary type of health issue that they involved. This showed that the most common issue was that the detainee had consumed drugs and/or was at risk of overdose (see Figure 16 below). This accounted for just under a fifth of all adverse incidents. 15% of cases involved detainees with either known heart problems and/or chest pain, and 12% involved the detainee experiencing some kind of trauma or injury. This often involved injuries to the head which required examination and/or treatment. There were also eight incidences in which the detainee appeared unresponsive and thus required medical attention. Often, this appears to have been the result of alcohol consumption.

In addition to the data shown in Figure 16 below, there were also three cases in which the primary issue was noted as a detainee feigning illness, and eleven cases in which a detainee was examined for an issue not otherwise coded, but appeared to be fit and well.

Figure 16: Nature of Health Problems in Adverse Incidents

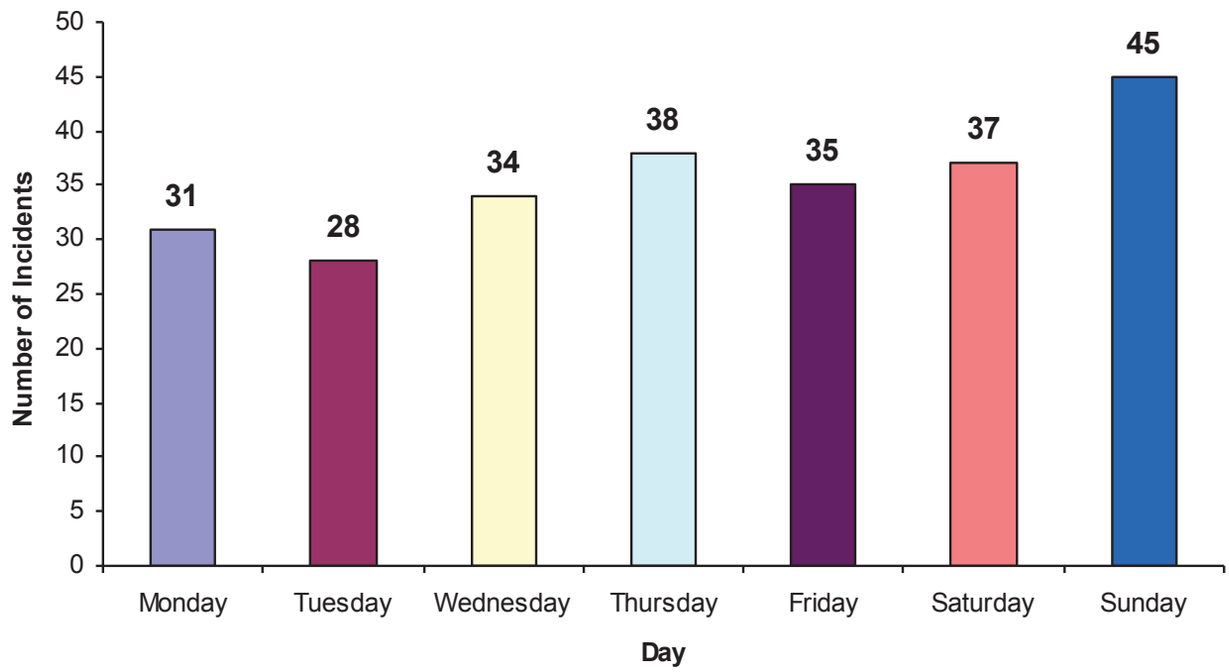


Self-harm

A total of 250 incidents of self-harm were examined. Data were collected to show the day of the week on which the incident occurred, the time at which the incident occurred, and the nature of the self-harm. The latter entries were very brief e.g. 'ligature, clothing' and as such were simply classified according to the method of self-harm.

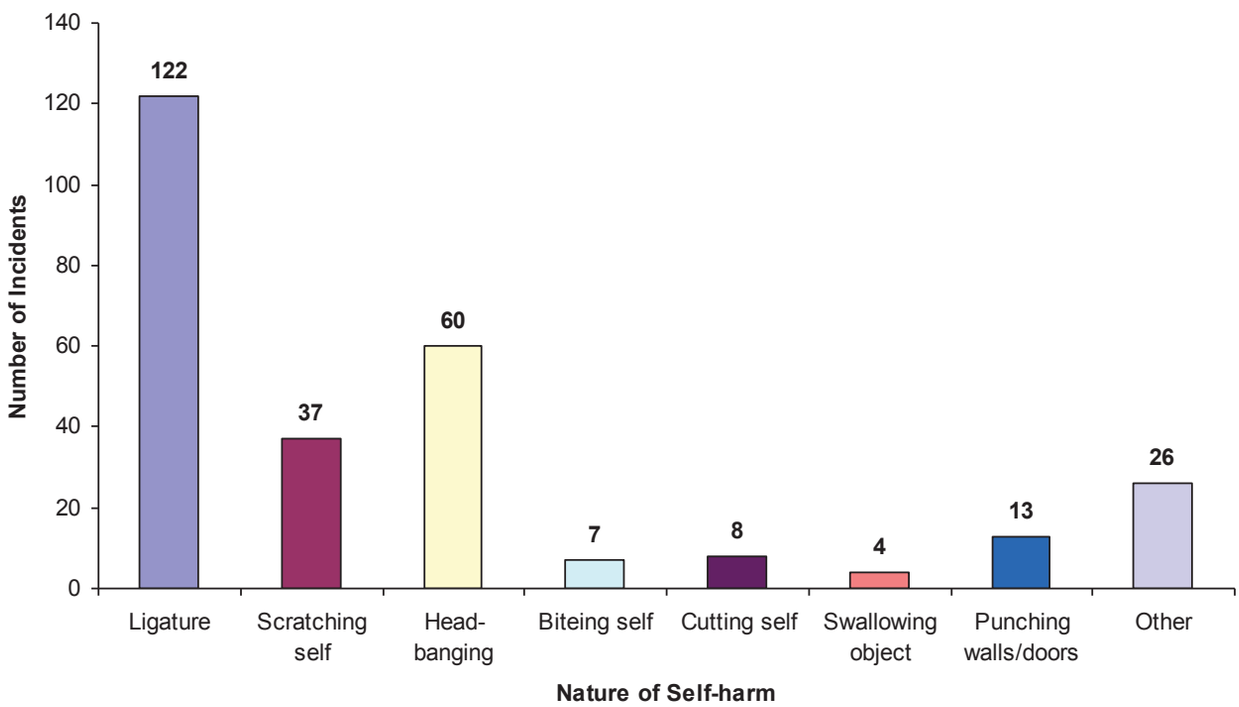
As shown below, the volume of incidents was fairly evenly spread across the week, although a slightly higher number (18%) of incidents occurred on a Sunday. There were two instances in which the day of the week upon which an incident occurred was not recorded.

Figure 17: Days upon Which Incidents of Self-Harm Occur



Incidents were classified according to the nature of self-harm that they involved. As shown in Figure 18 below, the majority of self-harm involved the detainee using a ligature, often made from their clothing. There were also 37 incidents in which a detainee scratched their self. This was often done using fingernails of parts of clothing such as zips, shoe eyelets, or jewellery. Incidents of head-banging usually occurred within the cell or a police vehicle.

Figure 18: Frequency and Type of Self-Harm



Incidents classified as ‘other’ include several instances in which a detainee made a claim of drug use which needed further investigation; instances in which the detainee made threats of self-harm which do not appear to have been followed through, for example ‘threaten to bite himself’; and instances in which a detainee attempted to strangle themselves with their own hands.

There were a total of 27 instances in which a detainee had self-harmed using more than one of the above methods.

Audit of Clinical Suites

A. NHS Infection Control Audit in Northumbria Custody Suites

Authors: Nicola Ellis & Tracy Wilson, Regional Offender Health Team (North West) – May 2012

Background:
Northumbria Police are one of ten Constabularies that are working in partnership with NHS Commissioners on the (wave 1) Early Adopter programme to work towards the transfer of accountability for commissioning Police related from the Home Office to the Department of Health. As part of this work, the Northumbria Healthcare Partnership Board agreed that there was a need to examine the care and facilities that are currently available within ten Custody Suites across Northumbria. The North East Offender Health Commissioning Unit approached the NHS Commissioners in the North West with a request that we complete this piece of work, replicating the process completed in the three wave 1 North West Constabularies.

Methodology:
The authors visited ten Custody Suites across the Constabulary and assessed each Clinical room against NHS Infection Control standards as recommended by the National Patient Safety Agency. Four of the Forces fourteen custody suites currently designated under PACE were not included in the audit as they are currently only used when demand requires. The template utilised was amended from a standard GP practice assessment in order to recognise the differences in facilities and services offered. The Infection Control template can be seen in Appendix G.

The authors assessed each clinical room against the template and the findings can be seen below.
Northumbria wide:

Police / Capital:

- Across all the suites, the emergency call button appeared to be close to the door and not in easy or discrete reach of clinical staff. The exception was Gateshead where a 'strip' call system was in situ around the room. This is a particular concern where the clinical room is not in immediate access to the booking in area. We were advised by some of the custody staff that some of the FME's refuse to allow custody staff to chaperone them whilst in consultation with detainees due to medical confidentiality. Whilst this is a reasonable rationale, the FME's could be placing themselves at undue risk of harm.

- Evidence is required to ascertain whether the cleaning contract / schedules meet NPSA standards for infection control. In order to meet this criteria all cleaning must be done to the British Institute of Cleaning Science standards (level 2)

- Evidence is required to clarify the contracts in place for waste disposal for clinical waste, sharps bins and pharmacy.

- Evidence is needed to ensure clinical waste bags are stored in a designated area which is not accessible to people or animals whilst awaiting collection.

- Across each of the ten sites, where antiseptic hand wash or hand was found, it was alcohol based (Chlorhexidine, Hydrex & Purcel) This contravenes the guidance laid down within SDHP 2006 and PACE, which states only alcohol free products should be used in order to comply with RTA requirements.

- Evidence is required to ensure Infection Control issues are discussed at Clinical Governance and / or Contact Monitoring meetings. This should include regular infection control audits and adherence to procedures.
- Evidence is required to assure that the clinical staff are aware of and adhere to infection control procedures.
- The cupboards storing clinical equipment should all lock automatically and require a key to open them.
- None of the ten clinical areas had a Dressing Trolley. This is required along with suitable cleaning products in order to ensure asceptic technique is adhered to when providing clinical care. However, currently there is an FME contract, the authors are not clear as to the expectations of clinicians within this contract. If the FME's are not expected to carry out 'hands on' clinical care such as wound closure or dressings, the trolleys may not be required.
- Ideally, the Examination Couches should be replaced with a height adjustable model in order to adhere to Health & Safety guidance.
- Although we are aware that there is a current programme to install pharmaceutical disposal bins across all sites, this is not complete. This work should be completed as a priority.
- There are no drugs fridges available in the clinical rooms. These fridges should only be used for storage of medications / dressings etc and not samples. They MUST NOT be standard domestic fridges as they are not fitted with temperature gauges.
- Only hand washing sinks are available, ideally an equipment sink would be available in which equipment can be cleaned. This is especially pertinent if clinical staff begin suturing within the custody suite and autoclavable equipment is used.
- Evidence is needed to clarify if the walls and ceiling in the clinical rooms are coated with a product that can withstand chemical cleaning.

The following items are currently provided by Northumbria Police but could be included in the specification for future custody healthcare services if desired.

- Evidence is required to ensure a simple protocol is in place which outlines the basic principles of microbiological hazards.
- There were no sterile examination gloves available for dressings. (they are not included within the Dressing Packs) These are essential in order to ensure asceptic technique is adhered to when carrying out dressings and other clinical procedures.
- Although appropriate sharps boxes were used and they were assembled correctly, they were not labelled as they should be according to accepted sharps waste disposal policy. Furthermore, in many suites there were numerous open boxes and they were stored on the floor.
- The clinical waste bags were not labelled in any of the clinical rooms, this contravenes accepted NHS clinical waste disposal policy.
- There are no posters above the sinks outlining a good hand washing protocol, nor was a policy / procedures booklet found.

- There was no evidence to demonstrate the maintenance, calibration and checking of clinical equipment e.g. resuscitation kits, blood sugar monitors.
- There are no rigid disposal bin for glass or aerosols. However, the sharps bin could be used for this purpose.

Site specific issues:

Bedlington:
- No couch covers / paper roll to cover the examination couch.
- Sterile products stored on the floor under the examination couch (CSI kits)
- Cotton roller towel in situ, should be disposable paper towels or electrical hand dryer.
- No sterile or non - sterile gloves, aprons, eye protection or gowns available for the clinical staff to utilise.
- Clinical waste bins are not foot operated.

Berwick:
- No couch covers / paper roll to cover the examination couch.
- No hand towels available.
- Taps on the hand washing basin are not elbow operated.
- No sterile or non - sterile gloves, aprons, eye protection or gowns available for the clinical staff to utilise.
- The sharps box had protruding sharps and was over ¾ full.
- Clinical waste bins are not foot operated.

Clifford Street:
- Only bar soap was available, no antibacterial soap or hand rub was in evidence.
- Only non - sterile gloves are available, no sterile gloves.
- No disposable /sterile gowns.
- The sharps bin is stored on the floor.
- Clinical waste bin is not foot operated.

Etal Lane:
- The room was cluttered with boxes and equipment around the room which could compromise the health & safety of staff and detainees.
- Only cotton roller towel was available, no disposable paper towels or electrical hand dryers.
- No antibacterial soap or hand rub was evident.
- No sterile gloves, aprons, eye protection or gowns available for the clinical staff to utilise.
- Clinical waste bin is not foot operated.

Gateshead:
- No paper roll was available, however, the examination couch was covered with a couch cover.
- No hand towels available and access to the hand washing sink was impeded by clinical waste bins.
- No sterile or non - sterile gloves, eye protection or gowns available for the clinical staff to utilise.
- The sharps box was on the floor.
- Clinical waste bin is not foot operated.
- The flooring was worn and chipped in places making it difficult to ensure a good standard of cleaning.

Gillbridge:

- The room was cluttered with boxes and equipment around the room which could compromise the health & safety of staff and detainees.
- No paper roll available to cover the examination couch.
- No hand towels are available.
- Access to the hand washing sink is impeded by a door and clinical waste bins.
- No sterile gloves, eye protection or gowns available for the clinical staff to utilise.
- The sharps box was stored on the floor, had protruding sharps and was more than ¾ full.
- Clinical waste bin is not foot operated.
- The radiator has chipped paint and rust, making it difficult to effectively clean.
- The walls have cracks / chipped paint and the ceiling has perforated tiles making it difficult to clean effectively.

Middle Engine Lane: *Please note, there are two clinical rooms available, however, only one is stocked and in use. Only the room that is used was audited.*

- Sterile supplies were stored on the floor (CSI Kits)
- Only cotton roller towel available, no paper towels or electrical hand dryers.
- No antibacterial soap or hand rub was available.
- No sterile gloves, eye protection or gowns available for the clinical staff to utilise.

South Shields:

- No paper roll, although the examination couch was covered by a couch cover.
- No antibacterial soap or hand rub was available.
- There are two sinks in situ, one has elbow operated taps, one does not.
- No sterile gloves, eye protection or gowns available for the clinical staff to utilise.
- The sharps box is stored on the floor.
- Clinical waste bin is not foot operated.

Southwick:

- No paper roll to cover the examination couch.
- Only bar soap is available, no antibacterial soap or hand rub.
- No hand towels are available.
- The taps at the hand washing sink are not elbow operated.
- No sterile gloves, eye protection or gowns available for the clinical staff to utilise.
- The drugs box is not secured to the wall.
- The sharps box is stored on the floor.
- Clinical waste bin is not foot operated.

Washington:

- No paper roll to cover the examination couch.
- Only cotton roller towel is available, no paper towels or electrical hand dryer.
- Only bar soap available, no antibacterial soap. The hand rub was alcohol based.
- No sterile gloves, eye protection or gowns available for the clinical staff to utilise.
- The sharps box is stored on the floor.

- Clinical waste bin is not foot operated.
- Insulin was stored in the drugs cupboard rather than in a drugs fridge.

Overall, the authors suggest that the draft action plan is adopted in order to ensure each of the clinical rooms adhere to the NPSA infection Control Guidelines. The draft action plan can be seen as appendix H.

Audit of the Custody Suites across Northumbria assessing compliance with guidance on the Safer Detention and Handling of Persons in Custody, 2006 (appendix 14) and FFLM guidance, 2007.

Authors: Nicola Ellis & Tracy Wilson, Regional Offender Health Team (North West) – May 2012.

Background:
Northumbria Police are one of ten Constabularies that are working in partnership with NHS Commissioners on the (wave 1) Early Adopter programme. This programme is working towards the transfer of accountability for commissioning Police related healthcare from the Home Office to the Department of Health. As part of this work, the Northumbria Healthcare Partnership Board agreed that there was a need to examine the care and facilities that are currently available within ten Custody Suites across Northumbria. The North East Offender Health Commissioning Unit approached the NHS Commissioners in the North West with a request that we complete this piece of work, replicating the process completed in the three wave 1 North West Constabularies. The North West Constabularies were audited prior to the publication of the Standards for the Detention and Handling of Persons in Custody (SDHP) 2012, hence, they were audited against SDHP, 2006. The North West Team, amended the existing template based upon the SDHP 2006 guidance to include the Faculty of Forensic and Legal Medicine (FFLM) 2007 and SDHP 2012.

Methodology:
The authors visited ten Custody Suites across the Constabulary and assessed each Clinical room against appendix 14 and FFLM requirements for equipment and supplies for Clinical rooms within Custody suites. Four of the Forces fourteen custody suites currently designated under PACE were not included in the audit as they are currently only used when demand requires. The template utilised was taken directly from SDHP, 2012 and FFLM, 2007 and as such examines compliance to Police and FME guidance.

The authors assessed each clinical room against the template and the findings can be seen below. The full findings and template used for each suite can be found in appendix G. A complete list of findings against the template has been provided and for each site, the items that ***were not available*** are listed.

Caveats:
Northumbria Constabulary currently have an FME contract in place for the delivery of healthcare within their custody suites. The North West Team has not had sight of the contracts in this regard and as such are not clear as to the expectations of clinical care provided. Furthermore, the authors were advised by Custody staff that the FME's bring their own equipment with them, which could explain the minimal amount of clinical equipment in the clinical rooms found during the audit.

Capital (Fixtures and fittings):
The following lists are those items that are expected in each clinical room within a Custody Suite as detailed within SDHP 2012 and FFLM 2007 guidance.

- Desk with a laminated surface.
- 3 plastic Chairs.
- Examination couch (ideally height adjustable)
- Lockable Store cupboards labelled to identify what they contain

- Drawers in the desk or suitable file for stationary
- Washbasin with elbow operated taps (preferably mixer taps) and tiling above the washbasin.
- Wall mounted examination light
- Clock.
- Notice Board suitable for self-adhesive putty / magnetic contacts.
- Telephone
- Panic Button
- Waste bin
- Clinical Waste Bin (wall mounted)
- Sharps Disposal Bin
- Pharmaceutical Waste Bin
- Paper towels and soap dispenser

In all of the custody suites, the authors found that where antiseptic hand wash was available, it was an alcohol-based product. This contravenes the guidance in the Road Traffic Act 1988, which suggests only alcohol free products should be used to reduce the risk of contaminated samples.

The following were missing in **all** suites:

- The chairs have a fabric cover rather than plastic.
- Clock.
- Notice Board suitable for self - adhesive putty.
- The clinical waste bins are not wall mounted and in most cases not foot operated.
- Examination couch are not height adjustable.
- Electric fan.
- Cotton roller towels were found in most clinical rooms, rather than disposable paper towels.
- Bar soap is the norm across the Constabulary, this should be replaced by non -alcohol antibacterial liquid soap with a dispenser.
- Drugs fridges are not available in any of the custody suites.
- The programme to attach pharmaceutical waste bins to the walls needs to be completed across the Constabulary.

Capital (Fixtures and Fittings) location specific:
The following were found to be missing in addition to those omissions within the clinical rooms in all custody suites:

Bedlington:
- Waste Bin
- Pharmaceutical waste bin

Berwick:
- Drawers in the desk or suitable file for stationary
- Waste Bin
- Pharmaceutical waste bin

Clifford Street:
- Drawers in the desk or suitable file for stationary
- Light
- Pharmaceutical waste bin

Etal Lane:
- Wall mounted examination light
- Pharmaceutical waste bin

Gateshead:
- Pharmaceutical waste bin

Gillbridge:
- Wall mounted examination light
- Drawers in the desk or suitable file for stationary
- Pharmaceutical waste bin

Middle Engine Lane:
- Wall mounted examination light

South Shields:
- Lockable Store cupboards labelled to identify what they contain
- Wall mounted examination light
- Elbow operated taps

Southwick:
- Drawers in the desk or suitable file for stationary
- Telephone

Washington:
- Drawers in the desk or suitable file for stationary
- Wall mounted examination light
- Clinical waste bin
- Sharps bin

Clinical Equipment:
The following lists are those clinical items that are expected in each clinical room within a Custody Suite as detailed within SDHP 2006 and FFLM 2007 guidance.

Resuscitation Equipment:
- Automated Defibrillator
- Bag - Valve – Mask with adult and child masks.
- Oropharangyl airways in a variety of sizes.
- Suction equipment (either electrical or hand operated)
- Pocket Face Masks
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Triangular bandages calico (only for use on supervised patients)
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic Wipes
- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 2 Sharpsafe disposal Bin 7L (one in use)
- 100 Clinical Waste bags 200mm x 320mm.
- 50 Clinical Waste bags 700mm x 1000mm
- 3 boxes Non sterile powder free vinyl gloves – various sizes
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues

- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- RTA 1988 Blood alcohol / drugs - minimum 10
- RTA 1988 Urine alcohol / drugs - minimum 10
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Clinical Equipment location specific:
Please note, this details the items that **ARE NOT** available:

Bedlington

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Suction equipment (either electrical or hand operated)
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 50 Clinical Waste bags 700mm x 1000mm
- 3 boxes Non sterile powder free vinyl gloves – various sizes
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- KY Jelly Sachets
- Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)

- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.

Forensic:
- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:
- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Other stationary as is in local use
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Berwick: Please note, the authors are advised by custody staff that all detainees requiring medical attention are transferred to Bedlington.

Resuscitation Equipment:
- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Suction equipment (either electrical or hand operated)
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:
- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:
- 30 Antiseptic sachets 25ml
- 2 x liquid soap

- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- FFLM Head injury instruction pads
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Clifford Street

Resuscitation Equipment:

- Oropharnagyl airways in a variety of sizes.
- Pocket face masks.
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 50 Clinical Waste bags 700mm x 1000mm
- 5 pairs of each size of sterile surgical powder free gloves

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Finger dressing applicators (for tubigauze)
- Low adhesive tape

- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- RTA 1988 Blood alcohol / drugs - minimum 10
- RTA 1988 Urine alcohol / drugs - minimum 10
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Etal Lane

Resuscitation Equipment:

- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)

Disinfectants and Antiseptics:

- 30 Antiseptic Wipes
- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 50 Clinical Waste bags 700mm x 1000mm
- 5 pairs of each size of sterile surgical powder free gloves

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)

- Other stationary as is in local use
- FFLM Head injury instruction pads
- HO / RT5 x 3 Pads

Gateshead

Resuscitation Equipment:

- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 3 boxes Non sterile powder free vinyl gloves – various sizes
- 5 pairs of each size of sterile surgical powder free gloves

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- 1 Forceps 11cm fine point
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)

- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Gillbridge

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing

- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 50 Clinical Waste bags 700mm x 1000mm
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Middle Engine Lane

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Pocket face masks.
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 50 Clinical Waste bags 700mm x 1000mm
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

South Shields

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.

- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 50 Clinical Waste bags 700mm x 1000mm
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose

- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- FFLM Head injury instruction pads
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Southwick: Please note, Southwick is a resilience suite, hence, not regularly utilised.

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Sanitary pads & Tampons.
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- RTA 1988 Blood alcohol / drugs - minimum 10
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Washington

Resuscitation Equipment:

- Bag - Valve – Mask with adult and child masks.
- Oropharnagyl airways in a variety of sizes.
- Suction equipment (either electrical or hand operated)
- Pocket face masks.
- Oxygen cylinder with delivery head, tubing and masks.

Disposable clinical equipment:

- Steristrip closure 6mm pack 36
- 2 Fabric dressing strip 6cm x 1m
- 2 Dressing fabric strip 8cm x 1m
- 2 Tubular support bandage B 1m
- 2 Tubular support bandage D 1m
- 2 Tubular support bandage F 1m
- 50 Johnson NA dressings 9.5cm
- 5 Micropore tapes 2.5cm x 5m
- 2 Elastic adhesive strapping 2.5cm
- 30 cotton wool 25G
- 5 boxes of adhesive dressing
- 20 Dressing packs (such as Cotton wool, gauze and are not the same as ambulance dressing packs)
- Tubigauze bandages size 01

Disinfectants and Antiseptics:

- 30 Antiseptic Wipes
- 30 Antiseptic sachets 25ml
- 2 x liquid soap
- 2 x non - alcohol hand rub

Protective items:

- 100 Clinical Waste bags 200mm x 320mm.
- 3 boxes Non sterile powder free vinyl gloves – various sizes
- 5 pairs of each size of sterile surgical powder free gloves
- Facemasks

Miscellaneous:

- Tablet Bags or bottles with labels (100)
- 2 x Paper towel rolls 250mm (one in use)
- 2 x Paper towels rolls 500mm (one in use)
- 2 Plastic bowls (1 pint) 150mm
- Paper cups
- SM Stitch Cutters (10)
- 1 Forceps 11cm fine point
- 1 Forceps dressing 125mm
- 1 scissors dressing 150mm
- Single use KY Jelly sachets
- 2 boxes Tissues
- 10 x 10ml disposable syringes
- Finger dressing applicators (for tubigauze)
- Low adhesive tape
- Test strips for urinalysis for blood and glucose
- Test strips for blood analysis for glucose
- Pregnancy test one step (2 tests)
- Disposable vaginal speculums (medium and small)
- Disposable Proctoscopes (Medium and small) minimum 2 of each size
- Containers and solution for the storage of contact lenses.
- Saline eye wash x 3

Forensic:

- Medical examination kits minimum 10
- Volunteer DNA kit
- Blood for alcohol / drugs - 10 each
- Hepatitis testing kits - minimum 5
- 5 Fibre Collection Kits

Stationary:

- Letterhead, plain paper, envelopes
- Carbon paper 10 sheets
- Body diagrams (10 of each view)
- Other stationary as is in local use
- FFLM Head injury instruction pads
- Detained persons medical care sheets
- FFLM Proformas: Section 4 RTA 1988, Fitness to Detain & Interview
- HO / RT5 x 3 Pads

Additional clinical equipment was available in each clinical room, including a variety of different dressing pads, all of which are clinically appropriate. The complete list can be seen in appendix 1.
Overall, the authors suggest that consideration is given to the type of service the FME's are contracted to provide. If they are offering consultation only, it is questionable how much clinical equipment they would

require. However, if there is an expectation that they provide 'hands on' clinical care such as dressings or skin closure, additional clinical equipment will be required as detailed by SDHP 2006 and FFLM 2007. Overall, the authors recommend the ordering system is revised in order to ensure the correct clinical equipment is available at all times within each clinical room. Acknowledgment is given to the fact that the SDHP list is not exhaustive in order to complete clinical tasks, indeed, in each custody suite additional items were found which are clinically appropriate.

References:

1. Operational procedures and equipment for medical rooms in Police stations and victim examination suites, FFLM 2007

2. Standards for the Detention and Handling of Persons in Custody (Appendix 14) 2006

3. Standards for the Detention and Handling of Persons in Custody 2012

4. Gap Analysis

An attempt was made in this section to assess the current healthcare scenario in the Northumberland police custody suites against existing standards for healthcare in custody. Existing standards are not, however, easy to determine. The HMIC has outlined a checklist for healthcare in custody for use in its monitoring visits (HMIC, 2012). The main headings used on inspection visits are clearly linked to detainees' entitlements under the PACE code and are as follows:

- Detainees are cared for by health care professionals and substance use workers who have the appropriate skills and training, in a safe, professional and caring manner that respects their decency, privacy and dignity
- Detainees are asked if they wish to see a health care professional and are able to request to see one at any time, for both physical and mental health needs, and are treated appropriately.
- Detainees receive prescribed medication if needed.
- Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred to community drugs/alcohol teams or prison drugs workers as necessary.
- A liaison and/or diversion scheme enables detainees with mental health problems to be identified and diverted into appropriate mental health services, or referred on to prison health services
- Police custody is not used as a place of safety for section 136 Mental Health Act (1983) (MHA) assessments.

It would have been inappropriate to use these criteria as a template against which to assess gaps in provision as they reflect the bare legal minimum requirements, for example, they say little about a potentially broader role that healthcare in custody might play in linking with mainstream primary care services. Whilst, the Care Quality Commission and Her Majesty's Inspectors of Prisons have developed care quality standards for healthcare in prisons this has not, as yet, extended to police custody (Commission for Healthcare and HMIC, 2009).

There is however a useful discussion of care standards in custody healthcare that arises from a research study by de Viggiani et al (2010). The study traces the evolution of commissioning in the police custody context in Dorset and has summarised the perceived benefits of transferring police health care budgets to the NHS (see Appendix E). The findings of this health needs assessment will now be discussed under headings modified from Appendix E. Existing 'gaps' in custody healthcare provision will thus be highlighted.

To provide timely, consistent, healthcare expertise in the assessment and treatment of detainees

The data analysis shows that 23% of all detainees receive an FME call out. Over a one year period there are therefore an estimated 16,100 FME call outs per annum. Whilst consumer satisfaction data show that the great majority of these call outs did not cause detainees any concern (82%) and that their needs were with fully or mostly met (76%) there was a significant subgroup that disagreed. One important reason for the detainee's dissatisfaction was the time spent in waiting for an FME to appear a finding that was underlined by the face-to-face interviews with custody sergeants and detention officers. It was clear that health delivery in custody needed to be more responsive and efficient.

Services to be provided by appropriately skilled and trained healthcare professionals

The FMEs delivering the current service are all GPs so are highly likely to be appropriately skilled and trained. Indeed, before taking on the role those new to the role have to shadow their more experienced

colleagues. However, the current FMEs receive no specific specialist training for the role. A further difficulty is that each episode of ill-health in custody that is assessed and treated by the current FMEs is seen in isolation and no attempt is made to inform, for example, the detainee's GP. The service should be expanded to include other healthcare professionals, providing a more consistent service, in situ, i.e. the custody suite itself. These other healthcare professionals are likely to be 'appropriately skilled and trained' nurses.

To provide seamless healthcare through the integration of health and offender services

There is a lack of integration within healthcare in the police custody setting. The FMEs provide a one-off consultation (most often to assess fitness to be detained, alcohol misuse, and the prescription of medication). Other healthcare workers are in and out of custody on a daily basis such as the drug/alcohol workers and the mental health liaison teams. The police and detention officers themselves are often involved in healthcare scenarios: administering drugs, escorting detainees to A and E and to chemists to pick up methadone scripts; observing alcohol and drug withdrawal in cells; responding to emergencies (calling in paramedics); and in the case of the custody sergeant undertaking an initial risk assessment. There is the need for integration of all this activity through one constant presence. This is likely to be a senior, trained, skilled clinical nurse.

To clearly communicate with detainee's GPs to ensure follow-up support

In order to achieve this important goal a new model of healthcare is required. Such communication with primary care is not undertaken at present.

To support robust lines of communication between the police and the NHS

There is currently strategic communication between the NHS and the police. Monthly partnership board meetings discuss for example the impact of the new custody contracting impetus with representatives from the North East Offender Health Commissioning Board. A new model of care would promote communication at an operational level as well.

To work with the NHS locally in order to trade on existing clinical and data governance structures and links to IT (including electronic records and video-links showing healthcare problems) and training

Currently there is no integration between broader systems within the NHS and police custody. Any new provider tendering for the health service in custody should demonstrate the manner in which this would improve. It is also worth pointing out that there is no integration presently between custody and FME records hence the manual exercise that was undertaken for this HNA.

To provide training for police custody teams

Any new provider of healthcare in custody should be asked to demonstrate how they would provide training to both the police and to detention officers. The topics are likely to include: resuscitation; risk assessment (including initial assessment if possible medical emergencies); alcohol and drug withdrawal; suicide, overdose and reduction in self-harm.

To develop high quality evidence-based care pathways and treatment protocols

A new healthcare provider should develop evidence-based care pathways and treatment protocols. This is likely to involve discussion with local NHS facilities such accident and emergency departments and the paramedical service.

To be regularly reviewed and monitored with the emphasis on development, equality, and continuous quality improvement

There are currently no statements about the quality of care that should be achieved in police custody. Any new tenderer for the service should demonstrate how audit, review and monitoring of the service will be achieved.

5. Implementation Plan and Recommendations

- This health needs assessment recommends that a new healthcare service in police custody is put out to tender.
- The tender specification should pay heed to the findings in this report.
- The successful tenderer should be asked to demonstrate how care standards in custody will be developed and audited.
- The successful tenderer should be asked to demonstrate how the healthcare model proposed integrates with a) The wider NHS especially primary health care b) the role of the police in the six custody suites
- A multidisciplinary team is required whereby there is the constant presence of a trained nurse in the six custody suites particularly at times when the demand is likely to be the highest (Thursday to Monday lunchtime especially 4pm to midnight)
- The nurses working in this team should be trained to prescribe opioid analgesia, painkillers and benzodiazepines
- The nurses working in these teams should be skilled at assessing fitness for interview, fitness for detention and in supervising drug/alcohol withdrawal.
- It would be sensible to have some kind of overarching supervision – a GP with forensic experience would be highly capable in providing such a service.
- Any new service model should be rigorously evaluated from the outset i.e. from the date the new service commences.
- The new provider should collect user views of healthcare in custody on a routine basis
- There should be an electronic link between the custody record and the description of healthcare provided in custody

6. Conclusion

A rigorous health needs assessment has been undertaken of the policy custody suites in Northumbria. The HNA used a variety of methods: an analysis of the literature; interviews with approximately 50 staff; data analysis of custody records linked to FME records; a survey of detainees' views; analysis of existing administrative databases for complaints and self-harm; and the report also includes an audit of equipment and infection control undertaken by colleagues in the North West. The Gap analysis that follows attempts to synthesise this information and to recommend the ways that healthcare in custody might be commissioned. It is clear that the present use of FMEs needs to change and that a broader healthcare team should be in place consistently. The team agrees that the report should be made available to future tenderers maybe in a revised and shortened form.

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Appendices

Appendix A: Competencies of Healthcare Professionals Working in Custody

The following could be performed by all three professions:

- Taking medical history
- Obtaining consent for treatment/disclosure of medial information
- Providing therapeutic interventions
- Assessing requirement for medication
- Advising referral to hospital
- Assessing fitness to be released (alcohol intoxication)
- Assessing fitness to transfer (general clinical assessment)
- Dealing with police officers injured whilst on duty
- Liaising with drug/alcohol referral workers
- Providing statements to police on request
- Attending court
- Providing reports (to solicitors, social services, CICA)

The following range of duties/procedures may be performed by police surgeons, but may only be undertaken by nurses/paramedics with appropriate prior training:

- Assessing fitness to be detained
- Assessing fitness to be charged (competence to comprehend)
- Assessing fitness for interview
- Advising requirement for appropriate adult (vulnerable, mentally disordered)
- Assessing person's ability to drive a motor vehicle (general clinical assessment)
- Taking forensic samples

Conducting clinical examinations can be undertaken by both nurses and paramedics if it is within the scope of their clinical guidelines. This also applies to paramedics with regards to administering medication (controlled drugs). Similarly, diagnosing clinical conditions may be an appropriate role for both nurses and paramedics, but only within defined competencies.

Finally, there are some procedures/duties which the guidance states may be more appropriate for some professions than others:

- Prescribing medication - can be undertaken by police surgeons, but not by paramedics, and only by some nurses (depending on competence and type of medication)
- Making precise documentation and forensic interpretation of injuries - can be undertaken by police surgeons with suitable prior training. Nurses and paramedics may document injuries, but training is needed for them to offer any forensic interpretation of injuries
- Undertaking intimate body searches (not on police premises) - may be performed by police surgeons with consent. However, the Nursing Midwifery Council advises caution for nurses if consent is not given. This role is not recommended for paramedics

- Pronouncing life extinct and giving opinion on any suspicious circumstances – can be performed by police surgeons. Nurses and paramedics would require training for the 'opinion' section of this duty
- Examining adults complaining of serious sexual assault and alleged perpetrators – may be performed by police surgeon, but should not be undertaken by nurses without appropriate prior training. Paramedics should not perform this role
- Examining alleged child victims of neglect, physical or sexual abuse - may be performed by police surgeon, but should not be undertaken by nurses without appropriate prior training. Paramedics should not perform this role
- Police surgeons and nurses may appear as an expert witness if they have suitable training and experience. However, this role is not recommended for paramedics

Guidance on the Safer Detention and Handling of Persons in Police Custody (ACPO, 2006) states that when recruiting custody nurses it is essential that they are at least 1988 Clinical Whitley Grade G level. This is because nurses with a lower level of qualification cannot diagnose. In addition, the guidance states that custody nurses should have: at least four years post-qualification experience; three years experience in Accident and Emergency, prison, custody of mental health; and completed the Intermediate Life Support Course (ACPO, 2006: 179). Paramedics working in custody environments should have paramedic qualifications, two years post-qualification experience and experience of working in custody or mental health settings.

Guidance on Responding to People with Mental Ill Health or Learning Disabilities states that "it is good practice for forces to appoint a mental health and learning disabilities liaison officer; each force that currently does not have one is expected to strongly consider this" (NPIA, 2010: 173)

Appendix B: Tender Outline from IHWUK

Methods

Ethical approval will be sought from the Chief Constable of Northumbria Police Force and research staff will be subject to police 'vetting' as appropriate. A data-sharing agreement will be completed between Northumbria Police Force and the research team. Following this, the objectives above will be met through completion of four modules as shown below.

Module 1: Corporate Health Needs Assessment

This module consists of research into the services currently being provided within each of the police stations across Northumbria. This will draw on a number of sources, including existing evidence (for example from a recent HMIC report) (Leighton), and interviews with key staff across the region (Brooker and Brown). Semi-structured interviews will be used to investigate:

- **Health Information Systems:** What information systems operate to capture health information in each police custody suite, how robust are they, and are they being utilised appropriately?
- **Understanding of Health Issues:** What major health and healthcare issues are already known in each setting?
- **Current Service Provision and Gaps:** Participants will be asked about the range of health services that are available in each setting and how effective they feel they are. Are there any gaps in current service provision? How do detainees access these services? What procedures would staff use to access other interventions/specialist advice? What quality standards are there? Do services meet these? Is there a lack of relevant referral processes in any area? How are those detained under section 136 managed and cared for?

These interviews will be conducted with a purposive sample of personnel from across the region, namely

- Head of criminal justice department x 1
- Chief Inspectors x 2
- Inspectors x 7
- Detention Officers x 6
- Custody Sergeants x 5
- Sergeant x 2
- Police constable - IOM x 1
- Youth Offending Service workers x 5
- Substance misuse service workers x 10
- Community Psychiatric Nurse – x 2
- Lead Forensic Medical Examiner x 2
- First contact clinical x 1
- Service manager x 1
- Former business manager x 1
- Criminal Justice lead nurse x 1
- Acting nurse consultant x 1
- Mental health team x 1
- PCT x 1

Interviews will be conducted in two week-long blocks in February and March 2012, with time between the blocks of interviews being utilised for initial reflection on themes.

Following discussions with the police it was agreed that detailed notes will be taken during each interview. Data will be analysed in order to elicit themes in terms the appropriateness of current health data collection systems, and in terms of what participants feel are the key health issues encountered by detainees, what currently works well to address their needs, what the current barriers to accessing health care are, and how improvements might be made. Data relating to service activity will be represented diagrammatically to show current pathways for service access, including any gaps in referral processes.

In addition, participants will be asked to provide the interviewers with copies of relevant policies/procedures if possible to allow them to map the range of services available in each setting and their referral routes. Finally, module one also includes an audit and inspection of the current facilities and equipment and recommendations for how they can be brought up to current police standards and current NHS standards (Linsley).

Module Two: Analysis of Detainees' Health Problems and Services Received
This module will consist of building an SPSS database from existing records, some of which are available electronically, and some of which are only available in hard-copy. Data from various sources will be anonymised and combined to produce an overview of a) the range of health problems experienced by detainees and b) the types of health services utilised in each of the custody settings in Northumbria during 2010 and 2011.

The sample for this strand of the health needs assessment will consist of a stratified random sample of records based on the age-sex (and if possible deprivation) profile across the entire area. This will be defined from the routine data collated by NEOHCU and will be representative for each station. An appropriate sample

size will be determined using power calculations, the expected population prevalence and standard error (Bruce et al., 2008).

Data will be analysed using appropriate non-parametric statistics, contingency tables and confidence intervals for proportions to achieve a number of outcomes:

1. To describe the population of each police station - including age, gender, ethnicity, reason for arrest, whether detainees were under the influence of alcohol or illegal substances at arrest, and whether they had a mental health problem. Additional information such as deprivation profile, whether English was the detainees' first language, whether they were registered with a GP and whether they were detained under a section 136 will also be included if possible.
2. A description of the range of health problems recorded for detainees in each data source. We will examine the degree of agreement between different data sources using Chi-square to highlight where there are differences in reporting. This will add to the data collected during module one in terms of whether the information systems currently operating to capture health information are robust and being utilised appropriately. In addition, it may lead to recommendations on ways of improving health screening in police settings. That is, any differences between data sources may highlight where there are currently shortfalls in health screening procedures, and areas in which routine screening may need to be improved in order to ensure appropriate service provision in the future.
3. A summary of the outcomes for detainees in terms of the services and/or interventions that they accessed whilst detained in police custody.

The types of health problems experienced by detainees and the types of services/interventions that they access will be reported for the whole area, and also broken down by detainees' demographics and by individual police stations.

Module Three: Survey of Detainees
The third module will consist of self-report questionnaire data from a convenience sample of detainees on their health status, access to services and preferences for care. Questionnaires will be sent to the six main custody suites in Northumbria during March 2012. They will be completed by a convenience sample of detainees during a two-week period whilst supervised by custody sergeants or detention officers. All detainees will be eligible to participate in this strand of the health needs assessment apart from those that custody staff believe to have a learning disability or an insufficient understanding of English.

Clearly not all eligible detainees will choose to participate in this strand of the health needs assessment. However, collection of demographic data will allow us to compare the characteristics of participants with those of the larger population of detainees in the region in order to assess how representative they are. The implications of any way in which participants in this strand differ substantially from the wider population of detainees will be discussed fully in the findings section of this report.

The findings from each of the above stages together with appropriate policy guidance will then be brought together to inform a gap analysis. This will chart current health service provision against the prevalence of health needs in each of the areas covered in Module Two. In addition, it will highlight where changes should be made to the structure or process or quality of current services to ensure effective service provision.

Module 4: Analysis of Complaints and Serious Untoward Incidents/Near Misses
This module consists of an examination of data from Complaints and Discipline for 2010 and 2011 including data on serious and untoward incidents and near misses. This will be anonymised and matched to the data collected in previous modules using unique participant identifiers. The data in each record of complaint will be manually coded into themes based on the subject of each complaint. This data will be fed into the final

report to contribute to both the gap analysis and the final recommendations for change. If a sufficient number of complaints/incidents were received over the two-year period the data will also be analysed to investigate whether the demographic characteristics of detainees and/or the nature of their health problems influence the nature of their complaints. That is, are people with particular characteristics/health problems more likely to complain about a particular shortcoming in service provision than those without those characteristics?

Appendix C: Custody Suite Profiles

Sunderland Area Command

Custody Suite	Sunderland Central Gillbridge Avenue	Sunderland North Southwick	Sunderland Washington	Sunderland Houghton-le-Spring
Total no. of cells	15	25	10	4
Total no. of camera cells	15+5 detention rooms	25+4 detention rooms	10+3 detention rooms	Believed to be zero
Male	12	23	8	3
Female	3	2	2	1
Juvenile cells	0	0	0	0
Total detention rooms	5	4	3	1
Type of suite and opening hours	24/7	Resilience (opens if everywhere else full)	24/7	Opens to house remand prisoners as required
Total arrests (complete year 2009/10)	9278	3856	7185	0
Total arrests (complete year 2010/11)	9114	1398	6529	0

South Tyneside Area Command

Custody Suite	Riverside
Total no. of cells	28
Total no. of camera cells	28+2 detention rooms
Male	24
Female	4
Juvenile cells	0
Total detention rooms	2
Type of suite and opening hours	24/7
Total arrests (complete year 2009/10)	6275
Total arrests (complete year 2010/11)	7706

Gateshead Area Command

Custody Suite	Gateshead	Whickham
Total no. of cells	15	8
Total no. of camera cells	15+3 detention rooms	0
Male	12	6
Female	3	2
Juvenile cells	0	0
Total detention rooms	3	2
Type of suite and opening hours	24/7	Resilience Red Risk Site*
Total arrests (complete year 2009/10)	8455	408
Total arrests (complete year 2010/11)	8130	760

*A Red Risk Site is a site so unsafe it requires a permanent floor walker should any prisoner be housed there. There is currently a report being considered requesting Whickham to be permanently shut.

North Tyneside Command Centre

Custody Suite	North Shields	Middle Engine Lane
Total no. of cells	15	44
Total no. of camera cells	Believed to be zero	
Male	10	
Female	5	
Juvenile cells	0	
Unisex cells		40
Dry cells		2
Close observation cells		2
Total detention rooms	5	3 holding cells
Type of suite and opening hours	Resilience	24/7
Total arrests (complete year 2009/10)	8979	0
Total arrests (complete year 2010/11)	5737	4075

Newcastle Area Command

Custody Suite	Etal Lane	Pilgrim Street	Byker
Total no. of cells	20	14	6
Total no. of camera cells	20+8 detention rooms	Unknown but unlikely ever to be used again	6+2 detention rooms
Male	17	10	5
Female	3	4	0*
Juvenile cells	0	0	0
Total detention rooms	8	4	2
Type of suite and opening hours	24/7	Unsafe, unlikely to be used again	24/7
Total arrests (complete year 2009/10)	11,464	10,988	1024
Total arrests (complete year 2010/11)	10,482	7122	3115

*Female wing (1 cell) closed off for terrorism detainees

Northumberland Area Command

Custody Suite	Bedlington	Blyth	Alnwick	Berwick	Hexham
Total no. of cells	16	6	6	5	5
Total no. of camera cells	16+4 detention rooms	Believed to be zero	6+2 detention rooms	5+1 detention rooms	5+2 detention rooms
Male	12	4	5	4	4
Female	4	2	1	1	1
Juvenile cells	0	0	0	0	0
Total detention rooms	4	2	2	1	2
Type of suite and opening hours	24/7	Resilience	Rural - demand led	Rural - demand led	Rural - demand led
Total arrests (complete year 2009/10)	8296	350	316	1046	556
Total arrests (complete year 2010/11)	7368	145	222	875	428

Appendix D: List of staff interviewed by custody suite

Northumbria Police HG, Penteland - February 27th

Gordon Milward	Head of Criminal Justice Department, Northumbria Police HQ
Carol Parkes	Chief Inspector, Force Custody Manager
Dave Harris	Chief Inspector, Criminal Justice Dept

Etal Lane - February 28th

Lorraine Hollis	DIP services manager, Turning Point
Lindsay Diston`	DIP services manager, Turning Point
Sarah Ecclestone	Social Worker, YOS
Stewart Alison	Social Work Team Manager (Forensic/Drug Alcohol)
Peter Temple	Senior Nurse, Addiction Services (Plummer Court)
Mark Roberts	CPN, NTW Mental Health Trust
Sylvia Todd	Detention Officer
Nina Berry	Inspector
Un-named	Custody Sergeant

Gateshead - February 29th

Roger Ashforth	Inspector
Ian Hunter	Detention Officer
Mark Hindhoff	Custody Sergeant
Liz Kaye	Police Constable, IOM
Clare Hegelberg	Drugs worker, Turning Point
Steve Green	CPN, Custody Suite/Crisis Team, NTW Mental Health Trust

South Tyneside - March 12th

Wendy Surtees	South of Tyne and Wear PCT
Karen Preston	Turning Point
Mark Joyce	First Contact Clinical (advises GPs on opiate dependent prescribing)
Ronnie Fraser	Custody Sergeant
Elizabeth Hirst	Detention Officer
Dean Walter	Sergeant

Sunderland – March 13th

Fiona Snowball	Inspector
Frank Whittle	Turning Point
Hilary Cowburn	Sunderland City Council Mental Health Team
Fiona Kilburn	South of Tyne service manager, Northumberland, Tyne and Wear NHS Trust
Graham Watson	Inspector
Deborah Lorraine	Youth Offending Services
Mike Shakesby	Youth Offending Services
Ian Johnson	Custody Sergeant
Adam Micallef	Detention Officer

North Tyneside – March 14th

Maureen Duffy	Former business manager
Maria Leonard	Criminal Justice Lead Nurse, NTW NHS Trust
Paula Routledge	Turning Point
Peter Temple	Senior Nurse Addictions, NTW

Mary Thirlaway	Youth Offending Service
Graham English	Acting nurse consultant, LD pathway, NTW
Alistair Oates	Inspector
Keith Hall	Inspector
Peter Ifland	Custody Sergeant
Christie Kirly	Detention Officer
Dr Alan Jones	Lead Forensic Medical Examiner

Northumberland – March 15th

Derek Shiel	Sergeant
Billy Benntett	Custody Sergeant
Andy Hayes	Detention Officer
Anne Allen	Inspector
Maria Leonard	Criminal Justice Lead Nurse, NTW NHS Trust
Julia Sharp	Northumberland DIP
Neil Whitfield	Northumberland Youth Offending Service

March 16th

Dr Fergus Patton	Lead Forensic Medical Examiner (telephone interview)

Appendix E: Benefits of transferring healthcare commissioning from the police to the NHS (de Viaganni et al, 2010)

To what extent does the currently commissioned custody healthcare service:

- Provide timely, consistent healthcare expertise and advice, in the assessment and treatment of detainees, victims of crime and police staff where appropriate
- Be provided by healthcare professionals with the appropriate skills and training to carry out the required duties in obtaining forensic samples and providing statements of evidence
- Ensure a seamless healthcare service by integrating health and offender services
- Increase the number of referrals to intervention schemes and support initiatives ensuring clear communication links with clients General Practitioners to ensure follow-up support. This will directly support initiatives, which assist in a reduction of re-offending rates and “revolving door offenders”
- Support robust lines of communication across the organizations (the police and the NHS)
- Realise the benefits of working with the local NHS, and other health and social care providers using pre-established out data Governance and clinical governance (including safeguarding, equality and diversity,), training and IT links
- Encourage training and development of police and healthcare custody teams
- Develop the Nurse Practitioners role in custody and forensic services
- Integrate high quality evidence- based care pathways and treatment protocols ensuring a coordinated approach across a range of settings
- Incorporate the use of innovation technology, including tele-medicine (the use of web-cameras and video links to show and discuss health problems with a specialist or colleague in another centre) and electronic records
- Be regularly monitored and reviewed with an emphasis on development and continuous quality improvement

Appendix F: Audit schedule utilised to assess the clinical rooms.

Infection Control Audit Tool

Custody Suite:

Date:

Section 1: Environment - Good Standards of general hygiene are maintained throughout the practice environment to ensure the health and safety of patients and staff.

1 Can the room be locked when not in use? ☐ Yes ☐ No ☐ N/A

Comments_____

2 Has the room an emergency call point? ☐ Yes ☐ No ☐ N/A

Comments_____

3. Has the room an emergency call point? ☐ Yes ☐ No ☐ N/A

Comments_____

4 Are attach buttons discreetly placed to allow operation with alerting the detainee?

☐ Yes ☐ No ☐ N/A

Comments_____

5 Is the CCTV in the room and does it infringe on privacy? ☐ Yes ☐ No ☐ N/A

Comments_____

6 Do cabinets lock automatically but require a key to open them? ☐ Yes ☐ No ☐ N/A

Comments_____

7 All general areas are clean and uncluttered demonstrating an adequate standard to ensure the health & safety of patients and staff ☐ Yes ☐ No ☐ N/A

Comments_____

8 Is the room located so that staff can respond quickly? ☐ Yes ☐ No ☐ N/A

Comments_____

9 Clinical rooms are clean and free from extraneous items. ☐ Yes ☐ No ☐ N/A

Comments_____

10 All sterile products are stored above floor level (excluding recent deliveries of new stock which are to be put away). ☐ Yes ☐ No ☐ N/A

Comments_____

11 Items of sterile equipment are in date (randomly select two items and check date).

☐ Yes ☐ No ☐ N/A

Comments_____

12 Dressing trolleys are clean and in a good state of repair. ☐ Yes ☐ No ☐ N/A

Comments_____

13 Examination/treatment couches are clean and in a good state of repair and height adjustable.

☐ Yes ☐ No ☐ N/A

Comments_____

14 Only single use disposable paper towelling is used to protect the couches (not linen sheets)

☐ Yes ☐ No ☐ N/A

Comments_____

Section 2: Hand Hygiene - Hands are washed and dried correctly to reduce the risk of cross infection.

1 Liquid soap is available at all sinks in the clinical areas (If bar soap is used it should be stored dry)

☐ Yes ☐ No ☐ N/A

Comments_____

2 Paper towels are available at all sinks in clinical areas. ☐ Yes ☐ No ☐ N/A

Comments_____

3. Re-useable hand towels (cotton) are not used. ☐ Yes ☐ No ☐ N/A

Comments_____

4 There is clear access to handwashing basins. ☐ Yes ☐ No ☐ N/A

Comments_____

5 The sinks are free from used equipment, e.g. instruments which are soaking.

☐ Yes ☐ No ☐ N/A

Comments_____

6 Non-alcohol hand rub / soap is available for use if required. ☐ Yes ☐ No ☐ N/A

Comments_____

7 A poster showing a good handwashing technique is available by at least one clinical sink or is in the policy manual. ☐ Yes ☐ No ☐ N/A

Comments_____

8 Sinks in clinical areas have elbow operated mixer taps. ☐ Yes ☐ No ☐ N/A

Comments_____

Section 3: Clinical Practices - Clinical practices are carried out to reflect infection control guidelines and reduce the risk of cross infection to patients, whilst providing appropriate protection to staff.

1 The following protective clothing is available for use by staff:-

a) Latex non-sterile and sterile gloves (powder free) ☐ Yes ☐ No ☐ N/A

Comments_____

b) Plastic disposable aprons ☐ Yes ☐ No ☐ N/A

Comments_____

c) Eye protection ☐ Yes ☐ No ☐ N/A

Comments_____

d) Disposable/re-useable gowns ☐ Yes ☐ No ☐ N/A

Comments_____

2 Is there a lockable drug cupboard which conforms with Medicines Management?

☐ Yes ☐ No ☐ N/A

Comments_____

3. Are there separate drug and sample fridges? ☐ Yes ☐ No ☐ N/A

Comments_____

4 Is there a secure pharmaceutical waste bin provided for the safe disposal of used drugs?

☐ Yes ☐ No ☐ N/A

Comments_____

Section 4: Equipment - Equipment is cleaned / decontaminated appropriately and stored correctly to protect patients from infection

1 There is no evidence of single use items being re-used, e.g. ring pessaries. ☐ Yes ☐ No ☐ N/A

Comments_____

2 Instruments are stored in clean areas prior to use and out of patient areas after use.

☐ Yes ☐ No ☐ N/A

Comments_____

3. Items of sterile equipment are in date (randomly select two items and check date).

☐ Yes ☐ No ☐ N/A

Comments_____

4 Items of sterile equipment are not stored at floor level. ☐ Yes ☐ No ☐ N/A

Comments_____

Section 5: Sharps Handling and Disposal - Sharps are handled and disposed of safely by the user to avoid the risk of sharps / inoculation injury

1 Sharps boxes are available for use and conform to British Standard BS7270 / UN3291.

☐ Yes ☐ No ☐ N/A

Comments_____

2 Sharp boxes are no more than ¾ full ☐ Yes ☐ No ☐ N/A

Comments_____

3. Sharp boxes have no protruding sharps. ☐ Yes ☐ No ☐ N/A

Comments_____

4 All sharps boxes are assembled correctly. ☐ Yes ☐ No ☐ N/A

Comments_____

5 Sharps box are labelled with the name of the practice before disposal as appropriate to locally agreed waste disposal policy

☐ Yes ☐ No ☐ N/A

Comments_____

6 Sharps boxes are stored above floor level and safely out of reach of children and visitors.

☐ Yes ☐ No ☐ N/A

Comments_____

Section 6: Waste Disposal - All waste from the primary care setting is segregated, its source identified and is stored, transported and disposed of in such a manner that the risk of infection or injury to health care staff and the general public is minimised.

1 There are written guidelines for waste disposal. ☐ Yes ☐ No ☐ N/A

Comments_____

2 Foot-operated bins are in working order in clinical areas and sluices. ☐ Yes ☐ No ☐ N/A

Comments_____

3. Bags are labelled with the name of practice as appropriate to locally agreed policy

☐ Yes ☐ No ☐ N/A

Comments_____

4 Household waste is placed in black bags and securely tied. ☐ Yes ☐ No ☐ N/A

Comments_____

5 Clinical waste is placed in yellow bags and labelled with the name of surgery ☐ Yes ☐ No ☐ N/A

Comments_____

6 Glass and aerosols are disposed of in rigid containers with no bag liner. ☐ Yes ☐ No ☐ N/A

Comments_____

7 Clinical waste is stored in a designated locked and inaccessible area to persons and animals

☐ Yes ☐ No ☐ N/A

Comments_____

Section 7: Minor Surgery - Minor surgery is carried out in an appropriately equipped environment

1 The floor covering is of a durable, washable type, in a clean condition and good state of repair

☐ Yes ☐ No ☐ N/A

Comments_____

2 Lighting is of a type that is easily cleaned. ☐ Yes ☐ No ☐ N/A

Comments_____

3. The room is equipped with some form of mechanical ventilation. ☐ Yes ☐ No ☐ N/A

Comments_____

4 Central heating radiators are clean and dust free ☐ Yes ☐ No ☐ N/A

Comments_____

5 A handwash basin separate from that used for washing of instruments is available.

☐ Yes ☐ No ☐ N/A

Comments_____

6 Elbow operated mixer taps are fitted to handwash basins. ☐ Yes ☐ No ☐ N/A

Comments_____

7 Antiseptic/detergent in a dispenser is available for surgical hand disinfection ☐ Yes ☐ No ☐ N/A

Comments_____

8 Sterile latex gloves and disposable plastic aprons are available for carrying out minor surgery

☐ Yes ☐ No ☐ N/A

Comments_____

9 Protective eyewear is available. ☐ Yes ☐ No ☐ N/A

Comments_____

10 Furniture and equipment appears clean. ☐ Yes ☐ No ☐ N/A

Comments_____

11 There is a foot operated waste bin for yellow clinical waste bags. ☐ Yes ☐ No ☐ N/A

Comments_____

Section 8: Minimal Invasive / Secondary Care Procedures

1 Walls and ceiling are in a good state of repair with washable covering, and able to withstand chemical disinfection when appropriate ☐ Yes ☐ No ☐ N/A

Comments_____

2 The fixtures and fittings in the procedure room provide a clean, uncluttered and safe environment for both staff and patients, suitable for the procedure for which application has been made

☐ Yes ☐ No ☐ N/A

Comments_____

3. The room is equipped with some form of mechanical ventilation ☐ Yes ☐ No ☐ N/A

Comments_____

4 Drugs and vaccines are stored according to the locally agreed policy ☐ Yes ☐ No ☐ N/A

Comments_____

5 Fridges are clean and tidy (in particular note clean and intact seals) and possess a thermometer for temperature monitoring ☐ Yes ☐ No ☐ N/A

Comments_____

6 Appropriate servicing, maintenance and user records exist for all equipment used in the procedure for which application is made ☐ Yes ☐ No ☐ N/A

Comments_____

Section 9: Minimal Invasive - There is evidence that a local infection control policy is being used and reviewed by the Practice on an annual basis

1 Documentary records exist to demonstrate that clinical governance meetings include reference to infection prevention and control ☐ Yes ☐ No ☐ N/A

Comments_____

2 Staff are aware of the local infection control guidance (ask a member of staff at random to give a brief outline of its contents) ☐ Yes ☐ No ☐ N/A

Comments_____

3. The basis principles of microbiological hazard of risk assessment for a clinical procedure have been outline in a simple protocol ☐ Yes ☐ No ☐ N/A

Comments_____

Appendix G: Draft action plan.

Issue: The cleaning contract / schedules meet NPSA standards for infection control. All cleaning of the clinical rooms is done to the British Institute of Cleaning Science standards (level 2)
Owner: Police

Evidence: _____

Timescale: _____

Issue: The clinical waste disposal contract meets NPSA standards.
Owner: Police

Evidence: _____

Timescale: _____

Issue: The sharps disposal contract meets NPSA standards.
Owner: Police

Evidence: _____

Timescale: _____

Issue: The pharmaceutical disposal contract meets the required standards.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Pharmaceutical waste bins are available in all the custody suites.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Only non - alcohol based hand wash / rub is available within the custody suites.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Infection Control issues are discussed at Clinical Governance and / or Contact Monitoring meetings.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: The cupboards utilised for storing clinical equipment should be replaced with automatically locking doors which require a key to open them.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Each of the ten clinical rooms has a dressing trolley.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Suitable cleaning products are available in each clinical room with which to disinfect the dressing trolley.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Each clinical room has an examination couch that is height adjustable.
Owner: Police

Evidence: _____

Timescale: _____

Issue: There is a drugs fridge available in each custody suite. This is particularly pertinent where insulin was found in the drugs cabinet rather than in a fridge (Washington)
Owner: Police

Evidence: _____

Timescale: _____

Issue: Where reusable clinical equipment is to be utilised such as suture sets, an equipment sink is available in each clinical room.
Owner: Police

Evidence: _____

Timescale: _____

Issue: The walls and ceiling in the clinical rooms are coated with a product that can withstand chemical cleaning.
Owner: Police

Evidence: _____

Timescale: _____

Issue: The emergency call bells are replaced with a strip or easily accessible system. Alternatively, a policy with regard to chaperones ensure the safety of clinical staff.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Cotton roller towels are replaced by disposable paper towels across all custody suites.
Owner: Police

Evidence: _____

Timescale: _____

Issue: In Southwick, Berwick and South Shields, the taps are replaced with elbow operated models.
Owner: Police

Evidence: _____

Timescale: _____

Issue: In Gateshead, the flooring is replaced to provide a smooth surface allowing adequate clinical cleaning.
Owner: Police

Evidence: _____

Timescale: _____

Issue: In Gillbridge, the radiator and walls are refurbished and the perforated ceiling tiles are replaced to ensure a smooth surface allowing adequate clinical cleaning.
Owner: Police

Evidence: _____

Timescale: _____

Issue: In Southwick, the drug storage box / cupboard is secured to the wall.
Owner: Police

Evidence: _____

Timescale: _____

Issue: All clinical rooms are checked for clutter and access to the sinks is not impeded.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Evidence is required to ensure clinical equipment undergoes the required maintenance and calibration e.g. Blood sugar machines.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Evidence is required to illustrate the regular checking of resuscitation equipment.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Evidence is required to illustrate clinical staff are aware of infection control principles.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: A simple protocol is in place which outlines the basic principles of microbiological hazards.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Powder free sterile examination gloves available in a variety of sizes for clinical staff.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: All sharps boxes are labelled according to accepted sharps waste disposal policy.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Clinical waste bags are labelled in all clinical rooms, as per accepted NHS clinical waste disposal policy.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Eye protection is available for clinical staff.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: Sterile products are not stored on the floor.
Owner: Police/Provider

Evidence: _____

Timescale: _____

Issue: All clinical waste bins are foot operated and in good working order.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Sharps bins are positioned on the wall, not on the floor which contravenes accepted sharps disposal guidelines.
Owner: Police

Evidence: _____

Timescale: _____

Issue: Paper roll with which to cover the examination couch is available in all clinical rooms.
Owner: Police

Evidence: _____

Timescale: _____

Issue: A poster outlining good hand washing technique is available above the hand washing sink
Owner: Police/Provider

Evidence: _____

Timescale: _____